G:\ALLEG\PANEL\20030110arb9.wpdALLEGATION REVIEW BOARD DISPOSITION RECORD

Allegation No.: RI-2003-A-0110
Site/Facility: Salem/Hope Creek
ARB Date: 01/29/2004

Branch Chief (AOC): Meyer
Acknowledged: Yes
Confidentiality Granted: No

Issue discussed: Current Actions on Tech Issues and SCWE

Alleger contacted prior to referral to licensee? Issue will not be referred to licensee until NRC has completed an interim review that adequately assesses the work environment at the station.

ALLEGATION REVIEW BOARD DECISIONS

Attendees: Chair - Blough Branch Chief (AOC) - Meyer SAC - Vito
OI Rep. - Neff, Wilson RI Counsel - Farrar
Others - Barber, Holody, Wingfield, Crlenjak

DISPOSITION ACTIONS:

1) [redacted] 7C

Responsible Person: Wilson
ECD: TBD
Closure Documentation: _____
Completed: _____

2) DRP to modify drafted violation(s) per ARB discussion and provide to Regional Counsel, OI and SAC.

Responsible Person: Barber
ECD: 2/6/04
Closure Documentation: _____
Completed: _____

3) DRP to compare depth of surveys at PSEG with those some other utilities such as Susquehanna. Provide documentation of results to SAC and OI for file.

Responsible Person: Meyer
ECD: 2/18/2004
Closure Documentation: _____
Completed: _____

4) Perform an interim assessment of the Salem and Hope Creek interviews completed to determine whether additional NRC action is needed to address work environment concerns. Consider Issuance of a letter describing the work environment issues identified to date and request PSEG review and assessment.

Responsible Person: All
ECD: 1/29/04
Closure Documentation: Letter to Licensee
Completed: 1/28/2004

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 5, 7C
FOIA- 2005-194

ARB MINUTES ARE REVIEWED AND APPROVED AT THE ARB

5) Continue the interviews of the key Hope Creek operations staff and shift managers. Upon completion of these interviews determine which additional licensee staff and management interviews are needed to confirm our interim assessment; better develop identified technical issues, identify new issues; investigate potential area of discrimination; and identify potential wrongdoing issues for referral to OI.

Responsible Person: Barber/Neff ECD: TBD
Closure Documentation: _____ Completed: _____

6) Upon completion of the additional interviews reconvene as needed to determine need for additional correspondence (beyond 1/28/04 letter) or other actions.

Responsible Person: All ECD: TBD
Closure Documentation: _____ Completed: _____

7) DRP/DRS to continue review of interview transcripts and provide summaries in terms of safety culture/SCWE and technical issues.

Responsible Person: Blough/Lanning ECD: Ongoing
Closure Documentation: _____ Completed: _____

8) DRP will continue to update the summary of technical issues on weekly basis considering information from additional information from interviews, and information from review of transcripts of completed interviews. DRS has completed review of TARP reports and NRB documentation and will discuss at the next ARB panel. DRP/DRS to assess.

Responsible Person: Meyer ECD: Ongoing
Closure Documentation: _____ Completed: _____

9) After receipt of the licensee assessment plan in response to our 1/28/04 letter, repanel to determine whether or not to provide the licensee additional detailed information on events reflected or SCWE.

Responsible Person: Panel ECD: 3/4/04
Closure Documentation: _____ Completed: _____

10) Repanel the listing of attributes/behaviors developed by the SAC as being representative of a good safety culture/SCWE, to be used as a point of comparison for outcomes of the SCWE review, and possibly considering how other events/activities/inspection findings at the site feed into that comparison.

Responsible Person: SAC ECD: TBD
Closure Documentation: _____ Completed: 1/29/04

11) Next periodic ARB

Responsible Person: SAC ECD: 2/18/2004 @ 10:00
Closure Documentation: _____ Completed: _____

SAFETY SIGNIFICANCE ASSESSMENT: SCWE Review

ARB MINUTES ARE REVIEWED AND APPROVED AT THE ARB

PRIORITY OF OI INVESTIGATION: **High**
If potential discrimination or wrongdoing and OI is not opening a case, provide rationale here (e.g., no prima facie, lack of specific indication of wrongdoing):
Rationale used to defer OI discrimination case (DOL case in progress):

ENFORCEMENT STATUTE OF LIMITATIONS CONSIDERATION (only applies to wrongdoing matters (including discrimination issues) that are under investigation by OI, DOL, or DOJ):
What is the potential violation and regulatory requirement?_____
When did the potential violation occur?_____
(Assign action to determine date, if unknown)
Once date of potential violation is established, SAC will assign AMS action to have another ARB at four (4) years from that date, to discuss enforcement statute of limitations issues.

NOTES: (Include other pertinent comments. Also include considerations related to licensee referral, if appropriate. Identify any potential generic issues)

Next ARB will include a discussion of suggestions for binning inputs related to SCWE (e.g., management production vs. safety pressure, non-conservative decision making, union pressures to suppress concerns identification, etc.) And how that will feed into the overall SCWE assessment.

Distribution: Panel Attendees, Regional Counsel, OI, Responsible Individuals (original to SAC)

ARB MINUTES ARE REVIEWED AND APPROVED AT THE ARB

BINNING OF SALEM/HOPE CREEK SCWE ISSUES

The objective of this binning is to establish the preliminary significance of issues that have been raised from a Salem/Hope Creek allegation (fall 2003) or that were identified during interviews conducted to assess this allegation.

The categories are ranked in decreasing order of safety significance.

Salem Nuclear Equipment Operator (NEO) Issues

PERCEIVED LACK OF FREEDOM TO RAISE SAFETY CONCERNS TO PSEG MANAGEMENT

- Environment believed to be intentionally cumbersome to discourage the identification and resolution of issues
  - [redacted] 10/22/03, p. 20
- Management is perceived as responding negatively when issues are raised (types of 'negative' responses: inequitable distribution of work, negative performance appraisals, withholding of pay raises, etc.)
  - [redacted] 10/22/03, p. 20, 23 & 47
  - [redacted] 11/7/03, p. 26 - 31

PRODUCTION OVER SAFETY ISSUES

- An [redacted] without authorization from the Control Room ... This was contrary to the Operating shift's intent to take the Main turbine offline to address a 20 foot steam plume from the affected valve ... Could be considered a violation of the Conduct of Operations procedure which prohibits operation of equipment without the operating shift's knowledge/permission
  - [redacted] 0/23/03, p. 56 - 58
  - [redacted] 11/7/03, p. 14 & 15
- The 24 Steam Generator Feed Regulating Valve (FRV), 248F19, failed to respond ... The NCOs, and at least one Senior Reactor Operator (SRO), on shift believed the valve was mechanically bound ... Management didn't want to declare the valve mechanically bound and therefore inoperable because that would require a Limiting Condition for Operation (LCO) 3.0.3. shutdown ... Management elected to pursue a controls failure ... Shutdown delayed for about 36 hours
  - [redacted] 0/23/03, p. 7 - 29
  - [redacted] 11/7/03, p. 16 & 17
- The operations department operates outside of established processes (i.e. cleaning condenser waterboxes) because of a 'just fix it and the unit(s) back up to full power' mentality ... An AOM used a metal bar to pry a Circulating Water Pump breaker into its cubicle in facilitation of a rapid return of the pump to support return to full power
  - [redacted] /22/03, p. 25 - 31, 33 - 37
- Overheard a member of Operations Management saying that he did not receive a raise at the end of 2003 after numerous instances of voicing an opinion in contrast to the 'production mentality' ... its built into their compensation package
  - [redacted] 0/22/03, p. 23 & 47
- Made an emergent change to the plant startup procedure to remove the restriction that the steam dumps be operated in automatic ... Conducted emergent training to extra NCOs and required them to control Reactor temperature and pressure (which affects reactivity) in manual instead of fixing the system to operate in automatic as designed
  - [redacted] 0/23/03, p. 40 - 48
- Main Steam Isolation Valves (MSIVs) were opened late during the startup following the 'hurricane-salting' shutdown
  - [redacted] 0/23/03, p. 32 - 40
- They have had NEOs operating the components required to synchronize and load the Emergency Diesel

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Salem Nuclear Equipment Operator (NEO) Issues

- [redacted] 10/22/03, p. 32 & 33
- Members of management doing union employee work ... [redacted] ... AOM using a metal bar to pry a Circulating Water Pump breaker into its cubicle ... AOM manipulating a Pressurizer valve ... Ops Supervisor manipulating an instrument nitrogen system pressure controller
  - [redacted] 10/22/03, p. 25 - 31
  - [redacted] 10/23/03, p. 55, 56 - 58, 59, 60 - 65

INDUSTRIAL SAFETY ISSUES

- A[redacted]imbed to an elevated Main Feedwater Pump Steam Isolation Valve without authorization from or notification of the Control Room to close it to isolate a 20 foot steam plume
  - [redacted] 10/23/03, p. 56 - 58
- A[redacted]sed a metal bar to pry a Circulating Water Pump breaker into its energized cubicle
  - [redacted] 0/22/03, p. 25 - 31, 33 - 37
  - [redacted] 10/23/03, p. 59 & 60
- Had to threaten OSHA involvement to affect resolution on a fan with exposed fan blades
  - [redacted] 10/22/03, p. 18

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Salem Shift Manager/Ops Superintendent (SM/OS) Issues

PERCEIVED LACK OF FREEDOM TO RAISE SAFETY CONCERNS TO PSEG MANAGEMENT

- Not observed yet. All personnel interviewed that they would not hesitate to raise a safety concern to management even though management's reaction may be to shoot the messenger.

PRODUCTION OVER SAFETY ISSUES

- An AOM.
  - o

SCHEDULE PRESSURE ISSUES

- During.
  - o

LABOR - MANAGEMENT ISSUES

- Union.

INDUSTRIAL SAFETY ISSUES

- During the recent Salem Unit 2 outage, a SW valve was stroked to allow system fill prior to setting the torque and limit switches. This was done to save time on the outage schedule. The valve destroyed itself when stroked remotely. Could have caused serious personnel injury if someone had been in the vicinity at the time of the failure.
  - o [redacted] 12/23/03, p. 37 - 39

BINNING OF SALEM/HOPE CREEK SCWE ISSUES

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- "... I get the impression that [workers] really don't care anymore. They're fed up with the five-year management teams coming in shaking up the world, changing policies and philosophies, and [the workers] feel as though they're not listened to ... [across the board]"
  - [redacted] 11/13/03, p. 5
- Threats and intimidation used against an individual for responding to a request by a shift manager
  - [redacted] 11/13/03, p. 10 - 14
- Indication of the disorganization within management - An individual had, simultaneously, 2 supervisors, 3 other people who give him direction ... Another person (whom he had never received any direction from) gave him his annual performance review (the written evaluation of which written by the person being evaluated)
  - [redacted] 11/13/03, p. 30 & 31

INDUSTRIAL SAFETY ISSUES

- Restart pressure exerted to fix a valve by flashlight vs. correcting the lighting deficiency ... the situation was eventually resolved by using temporary lighting
  - [redacted] 10/21/03, p. 53 - 60, 64 - 65
- During the recent Salem Unit 2 outage, a SW valve was stroked to allow system fill prior to setting the torque and limit switches. This was done to save time on the outage schedule. The valve destroyed itself when stroked remotely. Could have caused serious personnel injury if someone had been in the vicinity at the time of the failure.
  - [redacted] 11/13/03, p. 42

Salem/Hope Creek Allegation Background/Chronology

Issue/Event Date	Description
Jan. 28th, 2004	Issued a "significant letter" to PSEG providing them with interim results of our ongoing SCWE review (they have until February 27th to respond with an action plan).
Jan. 28th, 2004	Interviews conducted Jan. 7th and Jan. 28th
Dec. 31st, 2003	Interviews conducted Dec. 2nd and Dec. 31st
Nov. 13th, 2003	5th ARB
Nov. 12th, 2003	Interviews conducted Nov. 12th and Nov. 13th
Nov. 7th, 2003	4th ARB
Nov. 4th, 2003	Interviews conducted Nov. 4th through Nov. 7th
Oct. 28th, 2003	3rd ARB
Oct. 24th, 2003	Interviews conducted Oct. 24th through Oct. 29th
Oct. 23rd, 2003	Interviews conducted on Oct. 23rd

Salem/Hope Creek Allegation Background/Chronology 11

Issue/Event Date	Description
March 17th, 2003	1. **Hope Creek Reactivity Event** - Manipulation of Electro Hydraulic Control (EHC) system caused an **unanticipated rise in reactor power 6 ½ % to 13 %** ... not discovered until Wednesday (3/19/03). 2. Entering a planned shutdown to repair **3 technical/mechanical failures** (late Sunday / early Monday morning). 3. Monday morning (0800) Turbine Bypass Valve (TBV) stuck open (47%). TBV closed fully during subsequent testing. [redacted] argued with [redacted] about whether or not a shut down was required. The concern here was between [redacted] and his department heads. He apparently **"harassed"** (from interviews with [redacted]) **them for 4 hours on why a shutdown to repair the TBV was necessary** when all of the department heads believed that shutting down was a **"no brainer"**. Although non-conservative decision making is a possible root cause, there was no TS violation. 4. Heated discussions about the duration of the forced outage.
Mar. 28th, 2003	Alleger's last day on site (employment officially terminated this date).
Mar. 26th, 2003	Alleger told (by [redacted] that the [redacted] wanted the alleger **"out by Friday"** (March 28th, 2003).
Mar. 25th, 2003	Alleger submitted letter to CEO reiterating work environment concerns and describing the alleged retaliatory actions.
Feb. 26th, 2003	Alleger met with [redacted] to purportedly discuss [the] bonus. But, after discussing concerns about the work environment at Artificial Island, the alleger was informed of future termination (originally planned for April 16th). It was also alleged that the [redacted] then directed that the termination be "accelerated."
Nov. 2002	**Higher Tritium sample concentration in Spring 2003** - "a serious issue that had to be handled with kid gloves to keep us [PSEG] out of trouble" [redacted]
Fall 2002	Manager [redacted] directed an [redacted] **to NA a startup checklist step.** [redacted] tried to have [redacted] fired but was unsuccessful. Information received indicates this alleged activity may have actually occurred when [redacted] directed [redacted] to **"NA" a surveillance step for the Reactor Vessel Vent valves when a single valve indicated** dual indication during this routine stroking evolution. [redacted] was allegedly told by the Operation Crew that they would not "NA" the step. Earlier information from interviews suggested that the concern involved "NA-ing" a second verification containment walkdown to be done by a VP-OPS level person step. This step was added to the SU procedure as a lessons learned from the Davis-Besse issue. According to [redacted] this walkdown was actually done by himself and [redacted] and startup was delayed by a day because of leaks that they found from some SG wet layup level indication valves. So, the step was actually completed contrary to the alleger's assertion.
Sept. 24th, 2002	Based on the size and location of a significant steam leak (20' to 40' plume from the bonnet of a Feed Water Pump steam admission valve), the [redacted] agreed with the shift operators that the plant should be shut down to affect repairs. [redacted] left to speak with "upper management " and, upon his return, subsequently [redacted] which isolated the steam leak avoiding a shut down. [redacted] ECP confidential report substantiates allegation, Third Step Grievance [redacted] **without regard to his own personal safety, without a Nuclear Equipment Operator (NEO), and without the permission/knowledge of control room personnel).**