7C

From: David Vito
To: SALEMHCSCWE
Date: 2/18/04 8:51AM
Subject: Recent info submitted by RI-2003-A-0110 alleger and UCS

- SENSITIVE ALLEGATION INFORMATION -
- PROTECT APPROPRIATELY -

We should discuss this issue at the Update ARB tomorrow.

Please see the attached recent information submitted by the alleger. Initially we did not have the document to which she referred (an N1 review?). The document-in-question was later provided to Eileen N. by Dave Lochbaum. It appears, although I'm not absolutely sure, that the document was authored by [redacted] Salem/HC's Plan[redacted]. It's also not obvious why the review was done which prompted the development of the document. The document is an assessment of several Severity Level 1 Root Cause Assessments and reaches a conclusion that there is inadequate accountability at all levels of site management, and that his had been the cause of many recent problems at the facility. While I don't know everything that has happened at the site over the past few years, it appears that many, if not all, of the SL1 RCA's referred to in the document relate to issues already known by the NRC. In fact, for one issue, the author provided a previous comment made by NRC about the issue, and for another issue, the document specifically acknowledged that the issue was identified by the NRC. I ask that those with more knowledge than me about these items, review the document, and give me a read on our awareness of issues discussed therein and what our follow-up has been. It would appear to me that much of what is referred to in this document are similar issues to those which helped form the basis for our 1/28/04 letter to the licensee.

As you can see by the alleger's note, [redacted] has formed a conclusion, based on [redacted] review of this singular document, that the NRC should reconsider shutting down all the plants at Salem/HC before someone is killed or a nuclear disaster happens. [redacted] is expecting feeback on [redacted] comments, so I need to get back to [redacted] after I get some internal feedback on the N1 document. So, as before, thanks in advance for yourprompt review and comments. Please be ready to discuss at the ARB tomorrow, so that I can formulate an appropriate e-mail in response to [redacted] comments. My hope is that we can inform [redacted] that we are aware of the issues mentioned in the N1 document and that we wil incorporate this into our ongoing follow-up.

7C

1-18

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

From: Eileen Neff 05
To: A. Randolph Blough; Ernest Wilson; Glenn Meyer; Hubert J. Miller; Jeffrey Teator; Scott Barber; Theodore Wingfield
Date: 2/17/04 9:18AM
Subject: Fwd: PSEG internal report--URGENT-----PLEASE SHARE WITH HUB MILLER

I do not seem to have the document referred to in the alleger's email. Did she send it to anyone else?

CC: David Vito; Leanne Harrison; Sharon Johnson

1C

From: [redacted]
To: <DJV@nrc.gov>, <EXN1@nrc.gov>
Date: 2/15/04 11:19PM
Subject: PSEG internal report--URGENT-----PLEASE SHARE WITH HUB MILLER

Dave and Eileen,

Last week I sent you a copy of an internal PSEG Nuclear document, a newly written Level 1 Root Case Report on "Uncorrected Global and Interactive Organizational & Programmatic Issues." If you need another copy, let me know.

The report makes no mention of SCWE issues. Instead, it focuses on other issues plaguing the Salem and Hope Creek sites, issues clearly within the jurisdiction of the NRC.

While it is full of acronyms and somewhat difficult to follow, I read it closely tonight. I wish I had read it in detail before now.

It basically says this:

1. Senior managers, managers and supervisors do not assure that site activities are performed in accordance with PSEG Nuclear procedures.

2. Managers responsible for fixing organizational and programmatic (O&P) problems cannot do so because they have "inadequate knowledge" and inadequate follow-through. Basically, they cannot "fix" what they do not "see."

3. A lack of accountability is considered the "root cause" of many site issues.

4. Management ineffectiveness, strategic errors in business plan execution and lack of accountability impact plant reliability, nuclear safety and personnel safety---although the impact isn't specified in the report.

5. There is failure to use and follow procedures AT ALL ORGANIZATIONAL LEVELS--including Plant Managers, Vice Presidents, CNO, and above.

6. People rely on others to do a better job than they do themselves; as s result there is overconfidence, lack of thoroughness and attention to detail, complacency, and lack of required double-checking (QV&V, self-checking, independent verification, etc.).

7. The list of technical/near-miss events cited in the report makes all of the above clear, compelling, and in need of urgent attention.

When one looks at this report in total, and from a nontechnical vantage point, the following could be said in summary:

1. The Salem/Hope Creek site is led, run and staffed by people who:

   Do not follow procedures

   Do not see problems

Do not fix problems

Rely on others, not themselves, to be thorough and give attention to details

(and those people relied upon rely on others to be thorough---thus no one is really being thorough and paying attention to details!)

2. Things are getting worse, not better----"the frequency, number and potential severity of human performance and equipment problems has increased over the last 6 months." The report says:

MANAGEMENT [WILL] BE RESPONSIBLE IF SOMEONE DIES OR IS SERIOUSLY HURT.

SUPERVISION [IS] IRRESPONSIBLE, NEGLIGENT AND LEGALLY RESPONSIBLE.

3. LUCK/GOOD FORTUNE/DIVINE PROVIDENCE is the only thing saving the site from a disastrous event.

This is a most damning report on SALEM/HOPE CREEK. It is current. It is written by a PSEG Nuclear employee with a lot of integrity, insight, knowledge and documentation.

I am concerned, and frankly scared, that all the NRC oversight in the world cannot counteract the extent of these failings. Therefore, while well intentioned, Hub Miller's promise to me that on-site NRC inspectors will "step in if necessary" to avert an unsafe act is inadequate and insufficient. The failings are so widespread that inspectors cannot be replied upon to "catch everything" that is awry and potentially dangerous.

My "read" is that this report basically says it is only a matter of time before someone is seriously hurt, killed, or a nuclear event happens.

Why is the NRC allowing the Salem/Hope Creek units to be operated under such conditions?

Why isn't the NRC taking the keys away?

One year ago, one of PSEG 's own Directors expected the NRC to take such action.
And we have proof things are now worse, not better.

The report says the people who work at Salem/Hope Creek are increasingly at risk,
as is the general public.

Please act....NOW....don't wait for some arbitrary deadline or company report.
No matter what PSEG writes or tells you, these issues are real. So are the dangers they represent.

The NRC must exercise its responsibility and authority.

Further delays endanger all of us.

Act NOW.

MAKE 'SAFETY FIRST.'

Please.

I would appreciate hearing from each of you--and Hub Miller.

Thank you.

Kymn

[redacted]

TC

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Received: from igate.nrc.gov
by nrcgwia.nrc.gov; Sun, 15 Feb 2004 23:18:47 -0500
Received: from imo-r06.mx.aol.com (imo-r06.mx.aol.com [152.163.225.102])
by smtp-gateway ESMTPce id i1G4IMdb019935;
Sun, 15 Feb 2004 23:18:22 -0500 (EST)
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by imo-r06.mx.aol.com (mail_out_v36_r4.14.) id f.92.37b85dc (4468);
Sun, 15 Feb 2004 23:18:39 -0500 (EST)
From:[redacted]
Message-ID: <92.37b85dc.2d619e9e@aol.com>
Date: Sun, 15 Feb 2004 23:18:38 EST
Subject: PSEG internal report--URGENT-----PLEASE SHARE WITH HUB MILLER
To: DJV@nrc.gov, EXN1@nrc.gov
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X-Mailer: 9.0 for Windows sub 5007

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Content-Transfer-Encoding: 7bit

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From: Eileen Neff OY
To: A. Randolph Blough; David Vito; Ernest Wilson; Glenn Meyer; Hubert J. Miller; James Wiggins; Jeffrey Teator; Leanne Harrison; Scott Barber; Sharon Johnson; Theodore Wingfield
Date: 2/17/04 10:42AM
Subject: Fwd: PSEG report

From: "Dave Lochbaum" <dlochbaum@ucsusa.org>
To: <exn1@nrc.gov>
Date: 2/17/04 10:36AM
Subject: PSEG report

Hello Ms. Neff:

Kymn Harvin asked me to send along this PSEG report.

Thanks,

Dave Lochbaum
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Uncorrected Global and Interactive O&P Issues

1. Description of Condition:

There are global and interactive Organizational & Programmatic (O&P) issues that are identified as primary (root) causal factors in most of the recent SL-1 Root Cause Analysis (RCA) evaluations. An **Inadequate Accountability System** is the primary (root) causal factor to significant events that have been evaluated under SL-1 RCAs. See item 7, for explanation, bases and cited SL-1s.

For those RCAs evaluated, they are being addressed as a local issue only. This N1 explains the issue and should be closed out to SL-1 70033541, as a CRCA, to address these O&P causal factors on a global (site-wide) basis. There is no need to evaluate this N1 under a separate CR order, as conditions, causes, and corrective actions have been addressed under prior completed SL-1s and those in progress as described in item 7, below.

These are crosscutting O&P issues that are evidenced within and between every PSEG-Nuclear organization and work group. For each significant incident or event, the outcome is different (in terms of potential or actual SSC or plant consequence(s)); however, the cause is the same.

2. Safety Impact:
There is no direct SSC impact or to the safety or reliability of plant operations and/or personnel safety, at this time. Uncorrected, these global O&P causal factors have the potential to impact safety and reliability.

3. Requirement Not Met:
NAP-5, Section 3.0 Responsibilities, 'senior managers, managers and supervisors to assure that site activities are performed in accordance with PSEG Nuclear procedures.' And WMAP-2, section 3.6., managers are responsible for 'conducting analysis of O&P trend data and take appropriate action to fix or prevent the condition identified and to improve performance.' The uncorrected global factors identified may also involve violations of 10CFR50, Appendix B, Criterion V. to follow established procedures and Criterion XVI, Corrective Action.

4. Causes:
PSEG Management Team had inadequate knowledge of Global O&P issues and, as such, they were not corrected. The Management Team did not require appropriate and correct O&P identification, analysis nor corrective actions for many prior SL-1 (RCA) evaluations. As such, adequate trending of these issues was not performed and effectiveness of prior actions was not determined through validation.

5. Actions Taken:
Performed common and collective analysis of prior SL-1s (item 7) and initiated this N1 to:

A. Identify that there are uncorrected Global and Interactive O&P Issues,
B. Identify the primary (root) O&P causal factors, and
C. Take a CRCA (under SL-1 70033541) to work with the new Management Team to correct these issues.

Discussed this issue with SL-1 70033541 EVAL manager (the Maintenance Manager-Hope Creek) and the new Superintendent-Plant Support.

As this is a common station issue, contacted both stations' OS personnel to report this SL-1 N1, prior to taking it from the PRELIM status to that of CRTD.

6. Actions & Assignment of Responsibility to correct this issue:
Assign this N1 to Work Center C-SSS08.

Close this SL-1 N1 out to SL-1 CR 70033541 and SWIM should notify this N1 Initiator (NUACT) at extension 1340.

Upon this N1's allocation to 70033541, NUACT will create a CRCA to communicate this issue to the PSEG Management Team (through an E-mail using the manager's and supervisor's distribution lists) and will attach a memo for their use in implementing site-wide Accountability in work practices, work products and transfer of adequate and correct products to the next program, process and work group.

Analysis supporting this SL-1

7. Explanation, Bases & SL-1 RCAs:

An **Inadequate Accountability System** is the primary (root) causal factor to significant events that have been evaluated under SL-1 RCAs.

These two (2) global and interactive O&P primary (root) causal factors result in significant events:

Management Ineffectiveness, strategic error in business plan execution, Inadequate Accountability:
Organization-to-Organizational Deficiencies in Accountability:

These O&P factors result in the following; and they impact plant reliability, nuclear safety or personnel safety, and/or the design and licensing bases of our plants. The outcome also prevents meeting business goals.

* Failure to use and follow procedures at all organizational levels; and

* Inadequate work products are turned over from one Program/ Process to another, and from one individual to another, until all of the barriers have been breached and a consequence occurs. There is no 100% Accountability within work groups to produce quality products; and there is no 100% Accountability at each interface (program, process and individual). Dependence and complacency occurs as a result leading to consequence.

Note:
"Dependency" means that there was complete or too much reliance on the proper, correct or procedurally specified performance of some other program, process, and/or respected department or individual. From this, complacency is its resultant and naturally derived behavior. This term does NOT mean intentional inadequate care or no concern for the safety of others or plant equipment. Complacency does mean that given an over-reliance on another's performance, there is; little perceived need for concern, there is overconfidence and less diligence to work detail and thoroughness, a lack of following the program/process, and required checking (independent and self-checking/QV&V) is usually not performed. These Dependence/Complacency factors serve as strong and over-riding performance shaping factors within and at each interface in programs, processes and work groups.

Bases and cited SL-1s :

70027584, Ineffective Corrective Action

- Organizational and Programmatic Issues
- Inadequate management control to assure quality evaluations and effective actions
- At all organizational levels, personnel fail to use and follow the WMAP procedural requirements to assure quality and effectiveness of CAP EVALs and CRCAs
- NRC cites, "untimely corrective action, fix does not stick, or wrong fix".

70026001, 115VAC cable cut while still energized resulting in loss of the 11 Essential Controls Inverter and fire protection system affected. [Appendix R (Firewrap) Project work].

- **Organizational and Programmatic Issues:**
- Inadequate DCP instructions were transferred from program/process and work group to another until the consequence resulted.
- **There is inadequate lateral integration between the DCP preparation, Work Management (Planning & Scheduling) and Safety Tagging Processes.** The DCP work scope as it relates to equipment needing to be de-energized is not clearly communicated through the planning, scheduling, work clearance, and field installation areas.

70028106, 1PR2, Pressurizer PORV, Reassembled Without Spacer Resulting in RCS Leakage & Pressure Drop

- **Organizational and Programmatic Issues:**
- **Inadequate Accountability System & Org-to-Org Accountability for PMT:**

"With respect to the 1PR2 spacer not being installed, the Root Cause was attributed to Inadequate Work Practices. There is a global PSEG-Nuclear issue of inadequate work practices involving not using nor following established procedures."

- Technicians did not have, use or follow the procedure during 1PR2 reassembly.
- Technicians did not install the 1PR2 spacer as required by procedure.
- The technician initialed, as completed, a step that was not performed
- Maintenance Supervisor assigned unqualified craft to work the 1PR1 PORV.
- AOV diagnostic (AirCEt) testing as a Post-Maintenance Test (PMT),was only specified and conducted for 1PR1 and not for 1PR2.

70026521, Repeat Event- B FRVS Controller Setpoint Not at Required Setting (NRC found)

- **Organizational and Programmatic Issues:**
- **Inadequate Accountability System**
- technicians initialed (signed) that they had recorded the as-found set point value, although it was not recorded anywhere in the procedure.
- This also ties into the global O&P issue of failure to follow established procedures.

70032416, Repeat Adverse Trend-Scheduled LCO Window Durations

- **Organizational and Programmatic Issues:**
- **Cross-cutting organization-to-organization Accountability issue:**
- Planning & Scheduling does not assure scope freeze IAW WMAP-1; many additions are made in T-2 and many in T-0;this significantly impacts short-term LCO durations
- Inadequate WO tagging was identified in 4 of the 10 EDG LCO examples
- Supply Chain (SCM) many times had provided incorrect or defective parts;
- Walkdowns may not have been/ or not adequately performed by SWIM and/or Maintenance
- Or when Maintenance picks up parts to pre-stage them, all components or parts may not be available from SCM
- Operations does not assure that safety related SSCs are declared inoperable and tagged in a timely and coordinated manner to support actual maintenance work start times
- Maintenance may not have adequate knowledge of work scope (do not consistently attend T-week meetings or assign work to craft or shift unfamiliar with work scope or its status)
- Maintenance may not be able to start or complete work due to wrong or defective parts
- Maintenance may not have adequate resources, to do the work

- Engineering has not trended equipment performance to identify scope or PMT problems
- Engineering has not demonstrated field presence during critical LCO PM/CM or PMTs
- Operations sometimes is not timely (gaps not supported) on the back-end, i.e., in releasing tags and declaring the SSC operable; this occurs in short-term LCOs
- The above all have procedural requirements that have not been met.
- SCM, SWIM, Operations, and Maintenance failed to follow WMAP-1 to minimize critical SSCs' unavailability and meet scheduled LCO windows durations. Collectively, this results in incremental risk and impact upon the safety related functions of Mitigation Systems (NRC Reactor Safety Cornerstone No. 2).

70033541, A Rx Recirc MG set vent fan trip and B failed to auto-start -- Pwr reduction to 93%

- **Organizational and Programmatic Issues;**
- **Cross-cutting organization-to-organization Accountability issue:**
- Supply Chain (SCM) provided incorrect parts (mismatched drive belt sets)
- Maintenance installed mismatched drive belt sets
- SWIM, Mechanical Maint., & 12-hour shift fail to identify wrong procedure
- Maint. closed WO with Operations retest unsatisfactory
- Engineering trending and field presence of fan performance was nonexistent
- The above all have procedural requirements that were not met.

Problems with establishing accountability:

There is a global issue of personnel not using or following procedures, programs or policies; and this occurs at all organizational levels.

The frequency, number and potential severity of human performance and equipment problems has increased over the last six (6) months. If the undesired outcome involves a significant and debilitating personnel injury or fatality, management may incur vicarious liability, i.e., by failing to address low level performance problems, supervision may be found irresponsible, negligent and legally responsible.

Managers and supervisors have difficulty transitioning from verbal coaching and counseling to using the MARC checklists and writing memos to file. Many times, they do neither of these things, or use a checklist or rough notes and forget to file them.

Management Action Response Checklists (MARC) do not have standard memos that may be electronically edited for managers and supervisors to use in an easy, successful and consistent manner.

As such, on 10/16/02, this N1 initiator created an Accountability Memo that may be used by any supervisory management level. It will be transmitted for PSEG-Nuclear Management Team use as part of the CRCA that implements this N1 action.

Comments or questions may be addressed to A. Carolyn Taylor, Plant Support's Root Cause and Advanced O&P analysis expert, at extension 1340.

End of N1 Report.

Mail Envelope Properties (40336DF4.61F : 21 : 34876)

Subject: Recent info submitted by RI-2003-A-0110 alleger and UCS
Creation Date: 2/18/04 8:51AM
From: David Vito

Created By: DJV@nrc.gov

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