



UNITED STATES
NUCLEAR REGULATORY COMMISSION
OFFICE OF INVESTIGATIONS FIELD OFFICE, REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PENNSYLVANIA 19406

November 22, 1994

MEMORANDUM TO: Thomas T. Martin, Regional Administrator
Region I

FROM: Barry R. Letts, Director *[Signature]*
Office of Investigations Field Office, Region I

SUBJECT: SALEM GENERATING STATION, UNITS 1 AND 2: ALLEGED
HARASSMENT, INTIMIDATION, AND DISCRIMINATION (CASE
NO. 1-93-021S)

Enclosed, for whatever action you deem appropriate, is the Office of Investigations (OI) Report of Investigation concerning the above matter. Neither this memorandum nor the report may be released outside the NRC without the permission of the Director, OI. Internal NRC access and dissemination should be on a need-to-know basis. Treat as "Official Use Only."

Enclosure:
Report w/exhibits

cc w/encl:
J. Weddle, OI:HQ

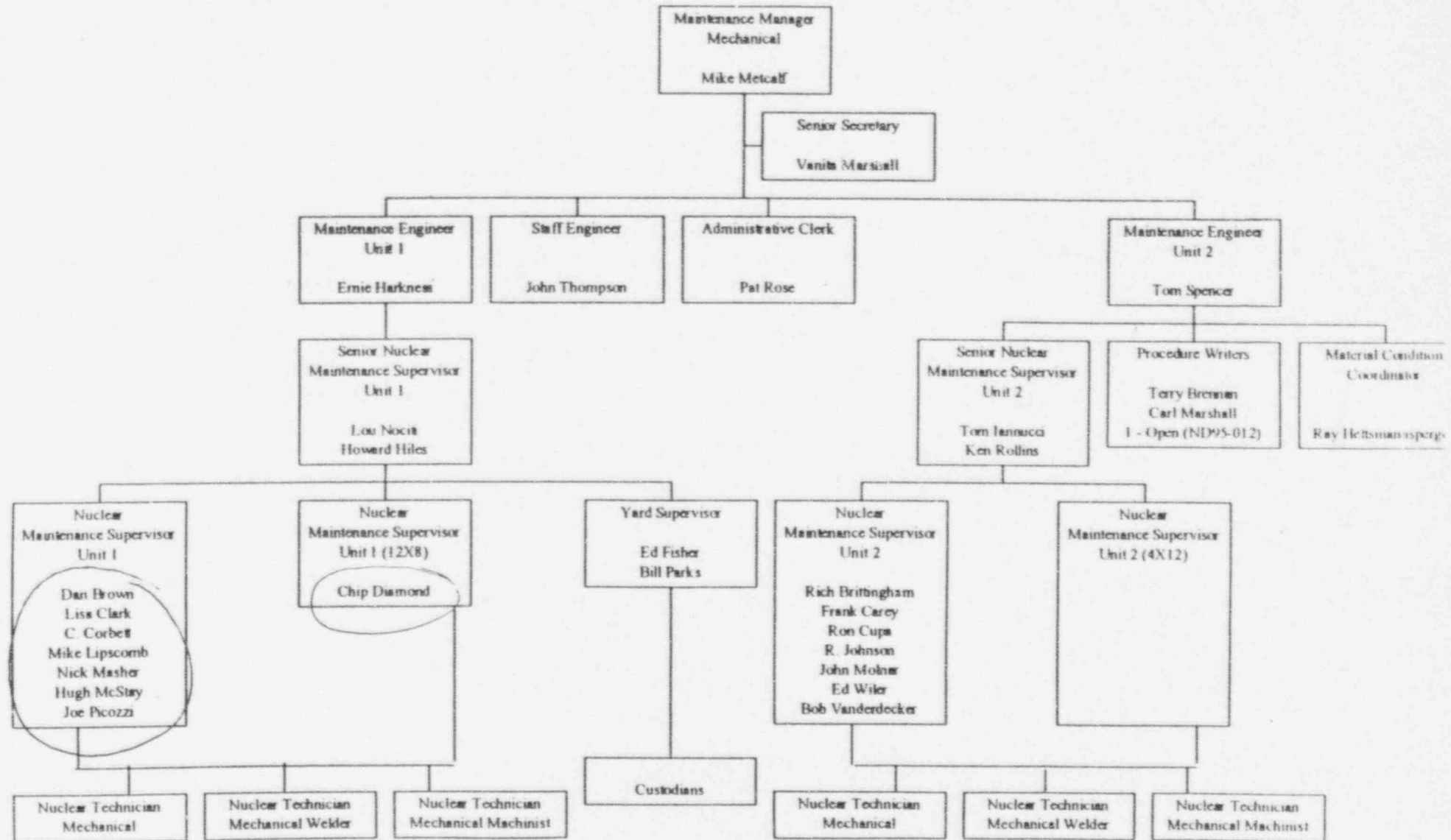
beginning
Jan '95 → beginning
May '95 (4 months data)

SALEM UNIT 1 - MECH MAINT 1st Level (1st line) Supervisors

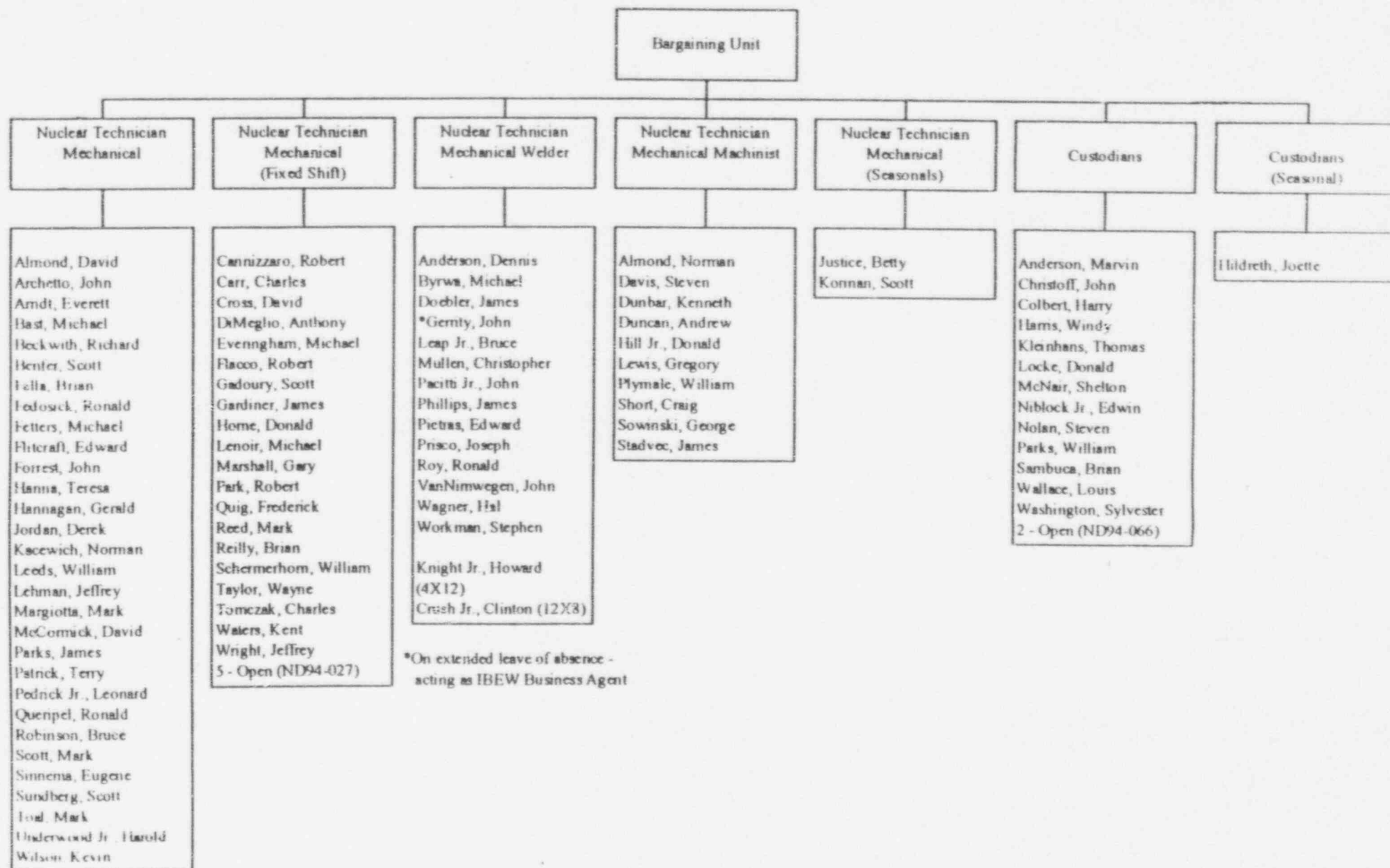
	16-CR	9-Aux	12,13-EDG	2-SW	3,4-7, Elec
D. Brown	~	15 days 8.5hr	~	26 days 9.2hr	22 days
L. Clark	~	36 days 36hr	~	8 days 1hr	~
C. Corbett	~	2 days 1hr	~	1 day 3 min	~
M. Lipscomb	~	24 days 6hr	~	14 days 4hr	~
M. Masher	~	28 days 15hr	~	21 days 5hr	33 days 3hr
H. McStay	~	24 days 12hr	~	16 days 6hr	12 days 2hrs
J. Picozzi	~	46 days 42hrs	~	15 days 2hr	40 days 1hr
C. Diamond	~	39 days 36hrs	~	19 days 3.5hr	10 days 1hr
Total		164 hrs		31 hrs	
Avg		21 hrs		4 hrs	

K/33

SALEM OPERATIONS - MAINTENANCE MECHANICAL DEPARTMENT - R/C 063



SALEM OPERATIONS - MAINTENANCE MECHANICAL DEPARTMENT - R/C 063



1/3 - 5/8/95

these count marks are days they were in the vital area. In some cases there are multiple entries per day. This, however, is denoted by the in bracket total time when I rounded up

	16-CR	9-Aux	12,13-EDG	2-SW	3,4-7, Elec sub, relay
Lee					
Catalfomo	daily	11/ 53 min		11/ 14 min	HHH HHH
Ops Mgr 1/3 - 5/5/95					
Brian	daily	HHH 2 hr		1 9 min	HHH HHH
O'Grady					
Ops Engr	daily	HHH 5 hr			
Pete Ott					
Ops Engr					
Bob					
Gallagher	daily	1 34 min		HHH 22 min	11
SNSS-Day					
Work Control					
Mike					
Gwartz					
Brian					
Hamilton					
Mike Healy					
Joe Serwan					
Work Control					
Toggery					
Bob Olsen					
SNSS-shift	daily	HHH 1 hr		11 8 min	HHH
Mario					
Kafartaria	daily	HHH 6.2 hrs		HHH 21 min	HHH
Steve					
Sauer					
Barry					
Birney					
Pat					
Bowdren					
Gabe					
Horneff					

The EDG over
cable is
disabled.
The EDG is
disabled.
The EDG is
disabled.

Note: where "daily" is written, that is an approximate
from once scan and put hard data like the rest.
For SNSS, "daily" applies to when they were on shift.

15/34

Slavik & Volodya

	16-CR	9-Aux	12,13-EDG	2-SW	24-7, Elec
Mike Morroni Maint I&C Mgr	~	/// 2 hr		///	/// /thr
Vince Gadzinski SN Maint Sup					
Bill Mokoid Maint Engr Unit 1	✓	/// 5 hr		1 18 min	/// 9.4 hr
Ron Heaton SN Maint Sup -1		/// 3.3 hr		/// 31 min	/// 3.6 hr
Jim Corbett SN Maint Sup -1					

Barry Birney

Pat Bowdren

Gabe Horneff

Tom O'Grady

SW

	Days	Time
Mike Metcalf Maint Mech Mgr	4	38 min
Ernie Harkness Maint Engr Unit 1	8	1.2 hrs
3rd level Low Nociti SN Maint Sup -1	7	37 min
2nd level Howard Hiles SN Maint Sup -1	10	2.3 hrs
Dan Brown N Maint Sup -1	27	9.2 hrs
Lisa Clark		

C. Corbe

Mike Lipscomb

Mick Masher

Hugh McStay

Joe Picozzi

Chip Diamond

Tom Spencer
Maint Engr Unit 2

SWGR & relay

1/2 - 5/5/95	16-CR	9-Aux	12,13-EDG	2-SW	3,4-7, Elec)
J. Summers		1111		1111	1111
		4 hrs		53 minutes	

* Days on which active
Total found in area

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: ____operOBS.s01_

Date: 05/10/95

Rev: 1

TITLE: OPERABILITY DETERMINATION (OD)

POTENTIAL ISSUE/OBSERVATION:

- Senior shift supervision has been challenged with making a large number of these determinations: in the space of a year, two three-inch binders have been filled with ODs.
- large number of ODs due to mostly equipment-related concerns and indicates a problem with design basis knowledge and the true configuration of the Salem units
- concern with the volume of ODs is compounded by the inspector determination that the bases used for operability determinations have not been properly justified (see examples in OPEROBS.S02)

REMARKS:

The OD process has led to the tolerance of degraded plant conditions involving safety-related systems (SECs, service water, battery chargers, hogan modules), where ODs have "justified" operability for individual components/cases without assessing or considering the effect of the condition on the true system operability

NEXT STEP:

Continue to observe operator consideration of operability issues; await licensee response to questions already posed

K135

XXXXOBS.Z##

NRC PREDECISIONAL

SALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: ____operOBS.s02__

Date: 05/10/95

Rev: 1

TITLE: OPERABILTY DETERMINATIONS

POTENTIAL ISSUE/OBSERVATION:

- SROs have not received any formal training on operability and do not always have the proper safety perspective when reviewing/accepting ODs (as demonstrated by the Ops Mgr having to correct the OD made on the 2A1 28vdc battery charger after system engineering provided and the SRO accepted an unjustifiable OD). Other examples:
 - OD for 125 vdc battery charger seal degradation used a 50.59 review that cited for its basis the fact that the battery seal was not specifically described in the UFSAR and therefore a safety evaluation was not required
 - OD for a non-qualified motor being used for the 22 RHR room cooler fan cited the fact that there was a redundant RHR train available, therefore the use of this motor was acceptable
 - OD for an erratically-performing steam flow channel cited that everything possible had been done to repair channel, therefore it was operable, but to be conservative, operators should use the other channel
 - OD for a faulty breaker for RCS sampling valves cited the fact that the valves failed in the safe closed position, therefore the breaker and valves were operable (without considering the design basis function of the valves)

ENGDEO01 (CONT)

- OD for RM 23 & 80 radiation monitor channels acknowledged that a DCP had somehow removed the reflash capability of those monitors and that the Tech Spec intention of the channel annunciation would not be met, yet the channels should be considered operable until one alarm was received, and then the other channels should be considered inoperable
- OD for RCS loop flow channel that showed erratic behavior twice within a week in January 1995 justified operability due to a contractor not being able to repeat the indications in April 1995
- OD for EDG fuses that were identified as being different than those intended justified operability via a PR which discussed functionality without considering the basis for the apparent design change (ie, no 50.59 review).

While the inspector was on site, operability issues arose concerning feed flow controllers, Hagan module transistors, the 28 vdc battery chargers, and the Unit 1 containment airlock seal. The engineering justifications for operability contained the same type of errors as those listed above, but the inspector observed an improvement in shift supervision level of acceptance: SROs were being coached by Ops management and did not accept the OD input from engineering until the proper considerations of operability had been addressed.

REMARKS:

Some secondary (BOP) ODs gave as justification the presence of primary plant protective features. This reflects an insensitivity to reducing BOP challenges to the primary plant.

NEXT STEP:

XXXXOBS.Z##

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: ____operOBS.s03_

Date: 05/10/95

Rev: 1

TITLE: OPERABILITY DETERMINATIONS

POTENTIAL ISSUE/OBSERVATION:

- The OD process has been very informal; no procedure/guideline on expectations, inconsistent input from engineering. Examples include:
 - the operability consideration for the service water system: a large number of discrepancies had been identified, each one singularly addressed, some with ODs, but no global assessment of the system operability was made until the NRC senior resident raised the issue to plant management; ie, neither ops nor system engineering recognized the requirement for this type of consideration).
 - a number of different mechanisms have been used by engineering to justify operability, often bypassing the proper use of a 50.59 review (ODs have been based on memos, problem report write-ups, work order comments, etc., without the proper perspective or collegial review)

REMARKS:

NEXT STEP:

examples

XXXXOBS.Z##

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: ___confOBS.S01__

Date: 05/10/95

Rev: 1

TITLE: CONFIGURATION CONTROL

POTENTIAL ISSUE/OBSERVATION:

- Configuration control and knowledge presents a continuing challenge to plant operators and maintenance personnel, due to inaccuracies in plant drawings, in component labeling and in TRIS (a review of the Incident Reports from the past month produced over 50 IRs identifying discrepancies in those areas).
 - 4/24 wrong fuses ID'd in Hagan modules
 - 4/25 service water sump pumps/level devices not wired IAW drawings; level device would not work if wired per print
 - 5/3 SPDS cabinet wiring discrepancy
 - 5/4 control air valve for temp. regulating valve ID'd as a spare in TRIS and on P&ID
 - 5/4 125 vdc battery charger dc output breaker not wired IAW print
 - 5/5 RCP seal water drawing does not accurately reflect as-installed systems (note: operability determination made in IR by system engineer)
 - 5/8 wiring configuration in 12 SGFP not per the wiring diagrams (note: conclusion made in IR that wiring was "equivalent" and presented no operability issue)

NOTE: Salem QA identified a configuration control problem during a review of a DCP and

XXXXOBS.Z##

NRC PREDECISIONAL

SALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: ____confOBS.s02_

Date: 05/10/95

Rev: 1

TITLE: SAFETY TAGGING

POTENTIAL ISSUE/OBSERVATION:

- Despite implementation of the new tagging office, with Operations personnel working much closer to station planners, tagging errors continue
- 4/26 service water sump pump breaker found in wrong position despite presence of shift supervisor admin tag
- 4/27 WO for work on 13 SW pump failed to include tagout of motor thermocouple - personnel and equipment safety hazard
- 5/1 operator walkdown ID'd the incorrect B building air cooled condenser listed on tagging request
- 5/5 improper valve position indicated on TRIS lineup for steam generator feed pump tagging order

REMARKS:

NEXT STEP:

5/11 Debnep

9

NRC PREDECISIONAL
SALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: CtrlOBS.T1B

Date: May 10, 1995

Rev: 1

TITLE: Prioritization of Work: Communication of and Follow-through on Priorities

POTENTIAL ISSUE/OBSERVATION:

Communications and coordination of actions on priority issues are weak.

Priorities not communicated clearly in meetings:

Inconsistencies in information provided at 630, 800, 830 and POD (1300) meetings - For example, ops priorities presented at 800 and 830 meetings on 5/8 were not the same.

Priorities not presented clearly and effectively - For example, Ops priorities listed in POD are not the same as the ops priorities that are verbally communicated at the end of the meeting. Also, at 830 meeting on 5/9, it was not communicated that power had been reduced due to a potential problem with 22A circulator, as a result evaluation was not performed promptly by engineering.

Personnel with key information are not always present or prepared for meetings - For example, no one working on circ water job for U2 was present at POD on 5/9 and group representative did not know status of work.

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
 Work control (CtrlOBS)
 Operability (OperOBS)
 Workarounds (RoundOBS)
 Maintenance (MaintOBS)
 Management (MgmtOBS)
 Miscellaneous (MiscOBS)

No: CtrlOBS.T1BDate: May 10, 1995Rev: 1

TITLE: Prioritization of Work: Communication of and Follow-through on Priorities

POTENTIAL ISSUE/OBSERVATION:

U2 28V DC battery issue was fraught with communications and coordination problems:

- 7 day TSAS entered at 1649 on 5/1
- Identified as an issue at meetings on 5/2
- On 5/3, ops was waiting for a work package to remove the ground detection system, DCP needed to be written
- On the morning of 5/4, ops was not satisfied with operability determination
- Later in the day, GM identified inadequate post mod test - went back to engineering for rewrite - DCP signed by GM at 930 pm
- Maintenance got package at 2 am on 5/5 - procedure required contacting installation and test personnel - Not sure how to contact appropriate personnel - tried until 4 am then decided to wait until dayshift
- Dayshift WCS in WCC had been told that 28V DC battery charger work (on both units) was #1 priority, but was not informed of plan for the work - maint supv brought 2 WOs to WCC and didn't clearly communicate what he needed from WCS - one of the WOs was to work on battery charger that was in service which caused WCS to question jobs
- Tagging requests had been prepared in advance in STC and delivered to WCC, but this was not known by anyone working in WCC - plan for work was established, but was not communicated (in NOB or through turnover) - confusion resulted in delay in authorization of 28V DC battery work and impacted other jobs on both unit including tagging of 12 SGFP

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: CtrlOBS.T2B

Date: May 10, 1995

Rev: 1

TITLE: Scheduling of Work: Scheduling and Tracking of
 Repetitive Tasks

POTENTIAL ISSUE/OBSERVATION:

Repetitive tasks (STs and PMs) not always scheduled to be performed before due date:

Surveillances - only a few, most due to unavoidable plant condition conflicts, but at least one due to problems with communications and tracking (I&C functionals this week)

Preventive Maintenance Tasks - large number - recent change in philosophy is reducing

PMDRs not always initiated in a timely manner (to allow disposition prior to overdue)

NRC PREDECISIONAL
SALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: CtrlOBS.T2C

Date: May 10, 1995

Rev: 2

TITLE: Scheduling of Work: Schedule Adherence/Sponsored Work

POTENTIAL ISSUE/OBSERVATION:

Sponsored work policy not clearly defined and not communicated to working level (on shift WCS and first line supervisors).

Definition of emergent work (work that must be sponsored) not clearly defined (i.e., expanded scope vs. new work)

SNSSs agreed on expectations for schedule adherence and communicated to WCSs - use POD to determine if work on schedule, but sponsored work concept not communicated. WCS indicated that would normally consult SNSS if work not on schedule, but would consider authorization of work on equipment that was already OOS or had no impact on ops.

Example - work pulled in while 13B SW pump OOS, but problem with parts identified later.

Sponsorship is not a formal process (usually communicated verbally) can be easily bypassed (intentionally or inadvertently) through scheduling process - Work is released based on POD which is updated by schedulers - no review - E&PB work that was not on schedule was added by scheduler - unintentional and no impact (incorrectly coded fill work), but indicates how easily process can be bypassed.

*may be
revised based
on additional
info*

*Sr scheduler / sr supr review list daily - by exception only
Only schedulers have capability to change dates in MMS*

NRC PREDECISIONAL
SALEM SIT OBSERVATION

Prob Ident (IdentOBS)
 Work control (CtrlOBS)
 Operability (OperOBS)
 Workarounds (RoundOBS)
 Maintenance (MaintOBS)
 Management (MgmtOBS)
 Miscellaneous (MiscOBS)

No: CtrlOBS.T3A

Date: May 10, 1995

Rev: 2

TITLE: Work Authorization: Changes to WCC Responsibilities

POTENTIAL ISSUE/OBSERVATION:

Changes to process when STC established aren't clearly defined in writing and haven't been clearly communicated to on-shift WCSs and first line supervisors which can cause confusion in WCC.

- No specific training provided to WCS - (Shift WCSs rotate periodically (i.e., monthly, biweekly - individuals may not have been in WCC for several months)
- No written guidelines or expectations

Process in flux - inconsistent implementation between units, maintenance supv., planning & scheduling, shifts, etc. and often different for emergent work vs. scheduled work (depending on urgency of work and resource availability)

Examples - Confusion on 13B SW pump work required WCS attention - work had been reviewed and set up for (tagging) previous day by SFC

*may be
curious*

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: CtrlOBS.T3B

Date: May 10, 1995

Rev: 2

TITLE: Work Authorization:Release of Work

POTENTIAL ISSUE/OBSERVATION:

Can work that does not require tagging bypass shift supervision in authorization process? What is expectation for shift supervision in authorization of work that doesn't require tagging?

PA status vs. WP status - SWCS in STC signed W/O indicating work authorized to begin after tags hung. Work released by WCC WCS after tags hung. Controlled by job supv. sign-on to tagout.

*May be
modified*

ENGDEO01 (CONT)

NRC PREDECISIONAL
SALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: CtrlOBS.T4A

Date: May 10, 1995

Rev: 2

TITLE: Quality of Work Packages

POTENTIAL ISSUE/OBSERVATION:

Still finding problems in work packages during job in spite of improvements in review process - For example, planning process didn't identify that U1 diesel CM required running the other diesels.

Known problem that PM packages don't meet standards - relying on feedback process to improve packages rather than correction during planning process. For example, DG gage calibration PM identified tags needed during performance.

Ops (STC/WCC) doesn't see whole work package.

Inappropriate use of troubleshooting procedures - not included in work packages for review.)?

Problems with bill of materials may warrant a broader review to correct problems with the BOMs than what is being done currently.

not presented @ design

NRC PREDECISIONAL
SALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: CtrlOBS.T1A

Date: May 10, 1995

Rev: 1

TITLE: Prioritization of Work: Setting Priorities

POTENTIAL ISSUE/OBSERVATION:

update
After work scope is defined, priority may change (i.e., U2 generator voltage regulator mismatch alarm) or priorities may be different for subsequent activities on the work order. If this isn't updated in MMIS, can work be missed (i.e., in outage) or improperly scheduled? *yes*

Expectations for timeliness of work initiation based on priority (i.e., priority B items will be worked by next working day) are not defined in writing, but there is a consistent understanding of these expectations throughout the organization - Are there performance indicators to track success rate at achieving expectations?

Look @ but don't have PIs

MGMTOBS.M3

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: MGMTOBS.M3

Date: 5/11/95

Rev: 2

TITLE: Licensee management does not exhibit a strong safety perspective.

POTENTIAL ISSUE/OBSERVATION:

Licensee management has not exhibited a strong safety perspective. Observed several instances where management "missed" the opportunity to demonstrate a safety perspective.

●on May 2 issue brought up at 8 am meeting that a maintenance worker was making changes to the configuration of the 28 volt battery charger with a Work order and without a DCP. No manager made issue of the unacceptability of this from a safety perspective.

●on May 4, Catalfomo did have issue with the quality of the Operability Determination for the 28 v battery charger issue, but he did not address at 8 am meeting. Instead, held back his comments until closed meeting, so safety perspective not demonstrated for all to see.

●on May 8 issue brought up by Harkness questioning operability and root cause related to the containment airlock door issue. This was a good example of a questioning attitude. However, he was shot down by Ops and others, and he backed down. Marshall questioned operability of door and apparent lack of root cause. Summers took issue with him and inferred that someone in room saying that dirt on seal constituted an adequate root cause analysis. Summers was reinforcing the wrong mind set with his comments. Others did not have an open mind to evaluate Harkness' concern regarding operability and root cause. After further evaluation, the dirt was not the root cause, instead the seal had degraded.

ENGDEO01 (CONT)

As the inspection has proceeded, Summers started to take issue with items at the 8 am meeting. However, these examples fall more into megawatt production issues.

- on May 5, 8 am meeting was a step change improvement in this issue. Summers took issue with the managers on the lack of work being done with the 28 volt battery charger, on their lack of knowledge of the 1B1 battery charger LCO times, and on the cleanliness condition of the plant at SW.

- on May 10, Summers pointed out and took issue with what appeared to be communication problems with the management of the OPs priority items - circ water pump issues involving imminent failures, 21 MSR drain tank level issue with scavenging part from Unit 1, and setting up of SORC meeting for T mod for 23B circ pump.

At the May 11 meeting, I saw good safety perspective:

- Morrone noted that for the AF21 air supply IR, not only was an Operability Determination needed but so was a 50.59 because the air supply was discussed in the FSAR. Licensing questioned the immediate reasonable assurance on operability. The GM noted GL 91-18.

- For the debris found in the 2SAC cooler, Catalfomo told the others not to fall into the trap of focusing on the debris as being the root cause of the higher temperatures for the SAC, without taking a good look at all possibilities.

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: MgmtOBS.m4

Date: 5/11/95

Rev: 2

TITLE: SORC Oversight

POTENTIAL ISSUE/OBSERVATION:

SORC took issue with the products presented to them at the May 3 SORC meeting:

weaknesses in EDG 1A starting air receiver low pressure alarm safety evaluation were pointed out. Specifically, the question Does the proposal reduce the margin of safety as defined in the basis for any TS? was answered: The margin of safety...is not reduced.....because the DG Air Start System and its components are not the subject of any TS or TS basis. This was an inappropriate answer because the DG are discussed in the TS and without the air start system the diesels would be considered inop.

T-mod on 95 -028 boiler feed iron sampling modification, Catalfomo ha a good personal safety concern regarding taking cap off at power (drain valve leaked through at another plant). Also concerned about potential of spraying sensitive instruments if tubing failed.

Although the SORC did identify these issues and handle them properly, all identification of weaknesses came from Catalfomo, not anyone else. Others in room contributed minimally (Morrini and Rinalli). I realize the SORC is a collegial body and that some comments will more likely come from one person rather than another. However, all members are supposed to review the material ahead of time and it was not apparent that anyone else on the SORC had identified that the SE question regarding TS was answered inappropriately. I would expect that all SORC members would be able to identify that the answer to the question was wrong. Follow up on this issue with Rinalli, proved that he was not clear on why that answer was inappropriate. (My concern here is that some of the members may not know enough to identify

ENGDEQ01 (CONT)

weaknesses in the products presented to them.)

The SORC is trying to understand their role and what it is that they expect of themselves and what they should expect of the people who present to them. They had a business meeting on May 3 at which they were critical of SORC performance and discussed the need for a step change in performance.

At the SORC, Rinalli did list the kind of things that they should routinely ask of the presenters (TS, Design basis, chapter 15 SA stuff).

mgmtOBS.M11

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: mgmtOBS.m11

Date: 5/11/95

Rev: 0

TITLE: Managers oversight of ongoing priority issues.

POTENTIAL ISSUE/OBSERVATION:

At the 8 am meetings it appeared that managers were not always in tune with the specifics of ongoing priority issues. They were unable to answer questions from the GM involving schedule issues, knowledge of LCO times, status of parts, knowledge of reasons for and understanding of work delays. As inspection went on, noted that the GM started to know more about the specifics and status of priority issues than the managers.

REMARKS:NEXT STEP:

Problem Identification Systems

1. Complexity of Systems

Trending of open items and accounting of issues is performed using two systems (PIRS and ATS). The complexities of having two independent systems coupled with sort and search limitations currently within the systems leads to challenges for the CAT team and line organizations being able to manage the incident report data.

1. obs.g8

Complexity also led to various prioritization schemes used for the current individual problem identification systems. This may result in a disconnect between site organizations as to what should be focussing on and the resources which should be applied. May also lead to managers developing different "mental models" of the problem areas and reduce the ability to focus in on important issues.

1. obs.g13
2. obs.g12

2. Trending of data

Measure of effectiveness - based on tabulation of workload indication not a measure of system performance or effectiveness of corrective actions. (ex. QA AR & OPS IRs)

Looks at overdue items does not consider items extended (not a good measure of what is in the system)

Does not appear to have a standardized method for tracking significant issues related to system/component performance. Individual System engineers may analyse IR's in some form or another. (Currently only see matrix IDing EOOS).

1. obs.g1
2. obs.g2

3. New Corrective Action Process

NAP-06 - does not provide definitive criteria for significance level determinations (Both the HIT team and the Inspection team identified a number of IRs which appeared to be misclassified to a lower than required level of significance) - EXAMPLES - 100' airlock - 2nd IR; Inappropriate entry into radiological area (repeat failure).

1. obs.g10

CAT Team -3 goals (immediate, backlog, oversight) not all being fully addressed due to the volume of emergent requests for support. Oversight function is most significant as that provides the means to judge the quality of causal evals by line orgs and effectiveness of the corr. actions.

1. obs.g9

Manpower considerations of implementation of new corr action system.

Analysis shows that IRs generated since 4/12 have resulted in approx. 1 man/yr of effort to line orgs and HIT team.

Also shows a lack of consistent expectation among the line organizations as to level of effort required for various levels of eval.

1. obs.g11

4. Root Cause Eval.

Sample reviewed - Evals based on recent corr action program very limited and just starting to come in.

Wide variation in the quality of the evaluations (level of detail). Could potentially limit effectiveness of system for trending/analysing issues on a generic level - due to inconsistencies in incident details.

Variability due in part to (1) apparent lack of formal root cause trng for individuals responsible for preparing evals.(2/7) and (2) lack of defined expectations in NAP-06 guidance for effort expected for such reviews.

1. obs.g5

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: ___IdentOBS.g13

Date: 05/08/95

Rev: 0

TITLE: Assignment of Priority to items identified through the
 various problem identification systems.

POTENTIAL ISSUE/OBSERVATION:

The team reviewed the various problem identification systems with the licensee to determine what systematic methods are used to prioritize problems which are entered into these systems (Table 1). The inspectors verified that for each problem identification system adequate administrative controls are in place to support consistent classification of new issues. A sample of problem reports were reviewed (including IRs, DR's, DEF's, and QA AR's) to assess the effectiveness of the licensee's prioritization processes. The inspectors did not find any significant problems with the current prioritization mechanisms used. The team did note that there are different prioritization processes used for almost each process which potentially adds complexity to administering the overall problem identification process. The licensee stated that they were currently addressing this issue in a revision to the corrective action program and that most of the problem identification systems would implement a common prioritization process when the revised program is put in place.

REMARKS:NEXT STEP:

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: ___IdentOBS.gl_

Date: 05/05_/95

Rev: 0

TITLE: Measure of how effective the organizations are at
 dispositioning action requests:

POTENTIAL ISSUE/OBSERVATION:

The team reviewed the licensee's processes used to track the effectiveness of corrective actions taken in response to problems identified through the various deficiency reporting systems. The current systems provide for tracking the number of currently open action requests, the line organization responsible for implementing the corrective actions, and the required implementation due dates. This provides a mechanism for periodically assessing how timely line organizations are at addressing corrective actions assigned to them. The current systems do not however provide "real-time" mechanisms for evaluating the "effectiveness" of the actions taken to address the initial concern including an analysis of issues in a generic manner. Additionally it does not appear that there are current mechanism in place to trend/analyze at a system or component level all outstanding action requests or the effectiveness of completed corrective actions associated with a system or component. The licensee stated that the Problem Identification Reporting System (PIRS) is currently undergoing modification which will provide a mechanism to evaluate the effectiveness of corrective actions in a systematic manner.

REMARKS:NEXT STEP:

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
Work control (CtrlOBS)
Operability (OperOBS)
Workarounds (RoundOBS)
Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: ___IdentOBS.g9

Date: 05/05_/95

Rev: 0

TITLE: HIT team

POTENTIAL ISSUE/OBSERVATION:

Emergent work is a big factor in the HIT teams ability to meet the charter expectations. To date have focussed on the IR and use of the interim guidance on assigning significance level to IRs. Have not gone greatly beyond the IR (e.g., DR, DEFs, ARs, etc...). The group has not been going back and looking at the entire database of backlog items, binning and systematically working through these due to resource constraints. The HIT team has been actively supporting emergent root cause analysis requests regarding #12 Charging pump, tagging issues, CR assembly mishandling event, etc. which has impacted ability to look at some of the other areas defined in the charter. Namely assessment of corrective actions and evaluation of the effectiveness of these corrective actions.

Based on discussion w/ HIT team, it appears that the teams activities can be categorized into three main areas: immediate support to line organizations, review and development of causal analyses for the backlog of problem reports, and an oversight function to independently evaluate the causal determinations developed by the cognizant line organizations for given problem reports and to evaluate the effectiveness of the currently evolving corrective action program.

The Inspectors reviewed the HIT team charter with members of the HIT team to determine how effective the team has been in addressing the goals and responsibilities described in the charter. The inspectors determined that the HIT team is attempting

NRC PREDECISIONALSALEM SIT OBSERVATION

Prob Ident (IdentOBS)
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Maintenance (MaintOBS)
Management (MgmtOBS)
Miscellaneous (MiscOBS)

No: ___IdentOBS.g11

Date: 05/08/95

Rev: 0

TITLE: IR backlog, current IR generation, and station manpower resource requirements

POTENTIAL ISSUE/OBSERVATION:

The team reviewed the current bi-weekly status reports generated by the HIT team to determine the number of incident reports that have been generated since the newly implemented corrective action process and the breakdown of those incident reports into the three significance levels. The team also determined an approximate time required to review and IR and provide causal determination, based on input from various line organization personnel and HIT team member assessments. The following was averages were assigned:

Level 1 - range 8 to 100 hours w/ 41 hour ave.	n=20
Level 2 - range 4 to 24 hours w/ 11 hour ave.	n=47
Level 3 - range 1 to 8 hours w/ 4.5 hour ave.	n=64

Given these figures in the period from 4/12/95 to the present the corrective action program has generated approximately 1625 man/hours of effort to review incident reports and determine causal factors for each. This time does not include the time necessary to take any corrective actions which may be identified as part of the causal evaluation.

Given this, the licensee needs to consider the resource requirements and current allocations to determine if sufficient resources are available to disposition the workload generated as a result of this program.

REMARKS:



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PENNSYLVANIA 19406-1410

July 6, 1995

MEMORANDUM TO: James C. Linville, Chief
Projects Branch 3
Division of Reactor Projects
Region I

THRU: Richard W. Cooper, II, Director
Division of Reactor Projects
Region I

FROM: Thomas T. Martin
Regional Administrator
Region I

SUBJECT: SALEM ASSESSMENT PANEL CHARTER

The purpose of this memorandum is to promulgate the charter for the formation of the Salem Assessment Panel (SAP). The principal purpose of the SAP is to assist Region I and NRR in the coordination of NRC resources for the performance monitoring and assessment of the Salem Nuclear Generating Station, as well as, the Public Service Electric & Gas (PSE&G) nuclear business unit. The scope of the SAP's activities will also include PSE&G's implementation of their performance improvement program for Salem.

The SAP charter reflects the guidance of Inspection Manual Chapter 0350, "Staff Guidelines for Restart Approval", and Region I Instruction 1470.1, "Licensee Performance Improvement Programs". Mr. James Linville is designated Chairman and Mr. John Stolz is designated Vice Chairman of the panel.

Panel Responsibilities:

- a. Review the licensee's improvement program and ensure it addresses problems/weaknesses identified by the NRC.
- b. Maintain an ongoing overview of licensee performance throughout the assessment panel process.
- c. Conduct periodic meetings with the licensee to discuss progress towards satisfactory completion of the program, and any NRC concerns. Generally, meetings with the licensee will be near the facility and open to the public for observation.
- d. Provide oversight of the NRC's followup activities. Review NRC inspection and assessment plans and findings, and facility performance; identify areas where NRC inspection and/or technical review are warranted.
- e. Periodically discuss the facility's inspection program (MIPS), and reallocate resources, as necessary, and recommend additional followup inspections based on licensee performance.

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- f. Periodically provide relevant assessment of licensee performance trends to NRC management.
- g. Recommend and coordinate enforcement actions.
- h. Assume the duties of the Restart Panel and develop a Restart Action Plan in accordance with NRC Manual Chapter 0350.
- i. Provide a recommendation for restart after the licensee satisfies conditions contained in the June 9, 1995 Confirmatory Action Letter.
- j. Following the satisfactory completion of the licensee's performance improvement program, provide a recommendation to the Regional Administrator for the cessation of the assessment panel.
- k. Membership:

James C. Linville, Chief, Reactor Projects Branch 3, DRP, Chairman
John Stolz, Director, Projects Directorate I-2, NRR - Vice Chairman
John R. White, Chief, Reactor Projects Section 2A, DRP
Eugene Kelly, Chief, Plant Systems Section, DRS
Leonard Olshan, Salem Project Manager, NRR
Charles Marschall, Salem Senior Resident Inspector
Scott Barber, Project Engineer, Reactor Projects Section 2A

Distribution:

Region I Docket Room (w/concurrences)

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M. Callahan, OCA

Inspection Program Branch, NRR (IPAS)

Kay Gallagher, DRP

Nuclear Safety Information Center (NSIC)

D. Screnci, (2)

PUBLIC

SALEM INSPECTION PROGRAM

10/26/95

Overview: The major inspection initiatives necessary to validate Salem performance improvement are being developed in parallel with the PSE&G development of their restart action plan. PSE&G will submit their plan in a letter around the end of November, and discuss in a meeting in mid-December. The Salem Assessment Panel will subsequently approve an inspection plan, and the plan will be documented with the 0350 checklist in a letter to the licensee.

Activities to Date:

A Salem EPPR was conducted on May 30, 1995, with recommendations on several areas. Since both units shutdown shortly thereafter, the SAP decided on August 2 to hold all initiative inspections until PSE&G developed their get-well plan. The inspection decisions made at the EPPR were no longer germane.

The 0350 checklist has been developed, in addition to a plant specific restart list of equipment and process issues. We have compared our list to date with the PSE&G action plan and there is good agreement.

An inspection initiative was conducted to review the results of their system certifications, as well as independently conduct our own walkdown of several systems. We concluded that their system reviews were comprehensive.

We have attended the major Management Review Committee presentations where they deliberated and agreed on the root causes and corrective actions necessary for broad performance improvement. Our assessment, to be captured in the SAP meeting minutes, is that their effort is extensive. This insight will be coupled with a review of their restart plan to prepare for the upcoming restart plan meeting.

Initial overview efforts have been accomplished on the Hagan Module project. This overview is being used to develop an inspection strategy.

Initiative inspections will be loaded onto MIPS following approval by the SAP. The non-core inspection hours expended during the last year have been heavily weighted toward reactive, with almost 50% of the 2000 reactive hours in operations. The majority of regional initiative inspection hours were charged to 40500 during the special team inspection conducted in May, 1995.

attachments:

Draft 0350 checklist
MIPS

K/37

SALEM ASSESSMENT PANEL MEETING

August 2, 1995

ATTENDEES:

J. Linville, DRP
C. Marshall, DRP
G. Kelly, DRS
J. Stolz, NRR
L. Olshan, NRR
J. White, DRP
S. Barber, DRP

OTHERS:

D. Cooper, DRP
C. Carpenter, OEDO

DISCUSSION:

The Salem Assessment Panel held its initial meeting on August 2, 1995, from 10:30 a.m., until 4:30 p.m. After introductions and a discussion of the charter by the chairman, the SAP completed its initial review of the Inspection Manual Chapter 0350, staff Guidelines for Restart Approval Process and Issue Checklists for status and applicability (Attachment 1). Open questions from the renew included:

- Will the licensee discuss root causes at the August 10, 1995, scoping process meeting? Chairman
- Will there be a description of the SAP process at the August 10, 1995 scoping process meeting? Chairman
- Does the licensee need to submit its restart plan and documentation of closure of other CAL items on the docket? Chairman
- Will public comments be sought on the licensee's restart plan? Chairman
- To what extent should state officials' involvement be sought? Chairman
- How will the MIP be made available to the State?

Next the SAP reviewed a preliminary list of SALEM Specific restart issues developed by the resident inspectors based upon a review of inspection reports. The SAP approved the preliminary list (attachment 2) recognizing that items could be added based on further reviews such as that of the SALEM IFS list to be completed by the resident inspectors or dropped based on discussions with the licensee. The SRI will review the item on the gas turbine to assure that it has some safety and regulatory basis.

DRAFT

DRAFT

The Section Chief then described the licensee's draft restart plan, some sections of which were provided to the SAP. It was noted that the licensee is conducting 46 individual system readiness reviews and departmental organizational readiness reviews to establish the scope of the outage. The licensee expects to complete this process for Unit 1 by the end of August. The SRI described the first system readiness review of the Spent Fuel Pool cooling system which he attended. It was agreed that Scott Barber and DRS inspectors should further assess this process to determine its effectiveness. One important measure will be whether the NRC Restart Issues appear within the licensee's scope as a result of this process. If not, the licensee should be questioned about the rationale.

The SAP briefly discussed the current MIP. It was agreed that routine resident core coverage necessary to monitor ongoing outage activities at Unit 1 and shutdown activities at Unit 2 are appropriate and the currently scheduled radiation protection and radwaste inspections should proceed on schedule because of Unit 1 outage activities. Other specialist core and initiative inspections should be deferred while the licensee is developing its restart plan reactive inspections associated with assessing the effectiveness of the scoping of the licensee's restart plan should be conducted as noted above.

Finally, it was noted that the chairman and other Region I Projects members of the SAP would meet with New Jersey Bureau of Nuclear Engineering Representatives after the Hope Creek SALP meeting on August 3 to discuss New Jersey involvement in the restart process.

It was agreed that the SAP would next convene after the scoping process meeting with the licensee on August 10, 1995, to discuss the open issues identified in this meeting, to discuss the near term MIP further, to discuss the member's reactions to the licensee presentation and to discuss available results of observations of system readiness reviews.

DRAFT

Salem Restart

Equipment Problems

- Control air system not reliable (94-19, 24, 35)
- CW screen motors burn up at low speed; can't be run in manual (95-10)
- EDG air start system carbon steel components (check valve problems) (94-19)
- EDG output breaker anomalies (95-10)
- EDG loading margin (95-07, 13)
- Feedwater system performance problems (oscillating pump speeds) (94-13)
- Fuses: Salem must insure that the correct fuses are installed in all applications and that the correct fuses will be installed in the future. (95-10)
- Gas turbine batteries need to be replaced again (what is the reliability of the GT if the batteries need to be replaced whenever one source of offsite power is lost?) (95-13)
- Hagan modules have not been compared to accurate controlled drawings to insure modules are correctly configured, parts have been replaced with non-equivalent parts by vendors, contract refurbishers, and maintenance staff without proper controls. (94-80, 95-02)
- Main steam isolation required for every turbine trip to prevent excessive RCS cooldown workaround due to problems with Main Condensor Steam Dumps and other leak paths. (95-13)
- PDP charging pumps not reliable (gas leakage, seal leakage, heat exchanger leakage, etc). (?)
- PORV (1PR1) leaks by the seat, requiring operation with the block valve closed. Valve should be repaired based on a root cause determination. (94-35)
- PORV accumulators may be undersized for RCS protection, assuming a transient starting at full RCS pressure. In reviewing, include history of operators need to close PORVs and start emergency air compressors (are accumulators leaking excessively?). (95-13)
- Pressurizer spray did not operate properly. As a result, operators used auxiliary spray. Did they follow procedures? Do the spray nozzles need to be inspected as a result of the 90° F water used (letdown was

Revision 0
August 2, 1995

isolated) (95-13)

- Radiation Monitoring System multiple problems (both units) (94-24)
- Reactor Coolant Pump oil collection systems do not contain oil effectively (94-33, 35)
- Reactor Coolant Pump seals - several failures in the last two operating cycles suggest root cause analysis weaknesses (94-32, 95-02)
- Reactor Head Vent valve stroke time failures (95-02)
- Residual Heat Removal: root cause of RH29 minimum flow valve failures (95-10)
- Residual Heat Removal: manual discharge valve (21RH10) makes a banging noise louder than other RH10 valves (95-10)
- Rod stepping - rods step in with no temperature error signal (94-19)
- SI pumps (high head CCP) have numerous deficiencies (flex hose installed, but not on drawings, repeated speed increaser problems, relief valves need to be replaced, etc). Review work history for pumps to determine recurring problems and potential common mode failures. Perform corrective maintenance based on root cause determinations. (95-13)
- SI pump suction boost - the TS minimum required SI pump flows would cause the pumps to go into runout; they did not consider the "suction boost" provided by the RHR pump. Salem has administratively lowered flow balance numbers for ECCS from the number in the TS surveillance. (95-13)
- SI relief valves: review design basis requirements and performance history (leakage on startups, etc). (94-13, 31, 95-01)
- Service water piping erosion; repair and thoroughly review basis for condition of SW piping in general. Repair/replace pipe as necessary. (95-07)
- Switchyard failures: review available vendor recommendations for preventative maintenance to insure that they have been incorporated. Perform a thorough root cause evaluation of switchyard failures, including quality of maintenance. (94-31)

Process Problems

- Bill Of Materials unreliable, MMIS not reliable or easy to use
procurement engineering unreliable (95-02)
- Configuration control - bolting, Hagan modules (E94-112-04013 in 94-80)
- Control of safety-related activities (hot-spot flushing without a
procedure or other mechanism to insure job performed safely, RH 29 test
without a test procedure). (95-03, 07)
- Control room indicators: all red-striped indicators should be repaired
based on a thorough root cause determination. (95-80)
- Engineering/Maintenance backlogs not evaluated for impact on safe plant
operation and ability to mitigate the consequences of an accident
(review previous safety evaluations for adequacy) (94-07) (95-80)
- Modifications such as a service water pump junction box change have been
performed as maintenance activities (95-07)
- Operability determinations are inadequate. (94-19, 95-10, 80, others)
- Operator performance (use of alarm response procedures, failure to close
block valves, repeated entry into (and abuse of) LCO action statements,
inadvertently purging PRT to containment, e.g.) (94-06, 80)
- Operator workarounds; need to be reviewed and those with an impact on
safe plant operation or that pose challenges to operators need to be
corrected. (95-80)
- Operating Experience feedback review (94-32)
- Planning: (for example;) frequently results in excessive LCO outage
time, with unplanned maintenance causing crisis management and
unnecessary challenge to operators. (95-07)
- Procedures, operations; evaluate root cause assessment with past
procedure problems. (95-02, 07, E94-113-04013)
- Root cause determinations not timely or adequate (95-02, 07, 10, 80)
- Safety Evaluations (10 CFR 10 50.59) like POPS are weak. (95-07)
- Setpoint control program - establish and implement. (95-13)
- System Engineering poor performance including equipment performance
trending and evaluation (95-07, 10, 80)

- Tagging/TRIS ineffective actions to prevent problem recurrence; problems addressed individually without thorough root cause (95-02,80)
- Work prioritization is not effective. Degraded components that could impact compliance with TS requirements frequently do not receive the proper priority. (This ties in with MMIS, the BOM, and the design basis). (95-80)
- Safety Evaluations are weak

People Problems

- Design Basis: Drawings have numerous errors. The ability to determine a system, subsystem, or component's intended safety function is severely impaired. The configuration baseline document (CBD) contains numerous errors, and frequently cannot be supported when challenged. The licensee has made changes in the docketed design basis assumed parameters for safe plant operation (e.g. POPS/LTOP) without submitting the changes for NRC review, when appropriate. (94-31, 95-07, 95-80) *System engineers don't understand can't find design basis or its relationship to s/r equipment.* (95-02,07)
- Plant Management approaches problems with the assumption that there is no safety problem, and no reason to interrupt plant operation. Plant management team does not focus on nuclear safety. Plant management team frequently does not recognize impact of degraded conditions on safety. They assume that an indeterminate state of operability equals operability until confronted with evidence to the contrary. They do not ask for evidence to the contrary. They do not challenge assumptions ("we have engineering assurance"). They have "a reasonable assurance of operability" without demanding a basis. This is a lack of appreciation of the basic principles of safe plant operation. Management must demonstrate the ability to assure safe plant operation before the Salem units are allowed to continue to operate. (Switchgear fans => inadequate operability determination, followed by determination of an USQ, followed by a request for a JCO, followed by a plant shutdown [the shutdown wasn't timely or adequate]; 22RHR29 assumed operable based on a test wherein the valve worked properly with no other evidence that the previous failure to operate properly had been addressed). (95-07, 95-10)
- Problem identification not effective in insuring problem identification, corrective action, and proper management focus. (Same as root cause determination, above) (95-02, 07, 10)

SALEM ASSESSMENT PANEL MEETING

November 14, 1995

ATTENDEES:

J. Linville, DRP
L. Nicholson, DRP
C. Marshall, DRP
G. Kelly, DRS
J. Stolz, NRR
S. Barber, DRP
L. Olshan, NRR

OTHERS:

R. Cooper, DRP

DISCUSSION:

The Salem Assessment Panel met call on November 14, 1995, from 10:30 a.m., until 2:30 p.m.

The panel discussed responsibility for closure of the restart issues as identified in revision 0 of the restart plan and agreed with the assignments as indicated. The panel noted that the plan restart issue list combined and consolidated several of the issues on the previous list and agreed that the appropriate references would be included on each of the the issues. After considerable discussion of proposed screening criteria for disposition of the restart issues, the panel agreed that all restart issues would be closed by the appropriate level of inspection for the issue.

In discussing the action plan observations, it was agreed that the following review assignments for the action plans would be completed before the end of November if possible but in all cases before the next panel meeting (Linville-human performance, DRS/Kelly-engineering, Ruland-equipment reliability, and Modes-training, DRP/Barber-corrective action, Schoppy-operations, Marschall/Depriest-maintenance, Fish-work control, NRR/self assessment) The review will include checking to assure that all related issues on the process restart issue list are included and development of questions for the scoping meeting based on discussion with the PSE&G sponsor.

The panel discussed the draft Senior Management Meeting full discussion paper and the attached MIP. It was agreed that inspection should be limited to certain core inspection of ongoing activities until the PSE&G Restart Plan is submitted and approved for implementation with the exception of reactive efforts and preliminary scoping discussions and/or a review of the plans for major significant issues such as the replacement and rebuild of Hagan modules because of the magnitude of the project, the Appendix R jumper issue which NRR will advise the licensee is not in compliance with the rule pending and expected December issuance of an SER, the emergency idesel generator loading issue and unit 2 shutdown risk. A RATI will be put on the MIP by DRP to support a tentative restart date for unit 1 of June 1996.

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J. Linville reported that discussions with New Jersey representatives indicated that the licensee is actively working to improve communications with the state and that the state seems satisfied that any state concerns can be resolved directly with the licensee. It was agreed that a state representative should be invited to the next panel meeting in order to identify any unresolved issues between New Jersey and the licensee before the public scoping meeting. It was also noted that Delaware has recently made an agreement on inspection accompaniments and that a DEMA representative should also be invited to the next panel meeting after discussing the agreement with the SLO.

The possibility of including Hope Creek under the oversight of the SAP was discussed briefly. L. Nicholson agreed to ask the Regional Administrator if a recommendation from the SAP on this issue is needed.

It was agreed that the next meeting should be held on December 7 and that other near term activities are as follow:

- 12/1-PSE&G expected to submit Restart Plan
- 12/4-Engineering Meeting
- 12/7-SAP Meeting
- 12/8-Brief Regional Administrator/Deputy Site Visit
- 12/11-Scoping Meeting with PSE&G
- 12/18-Public Meeting to receive comments on PSE&G Restart Plan