ATTACHMENT 10

UNITED STATES NUCLEAR REGULATORY COMMISSION
REGION 1

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

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

PRESENT:

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

LEON ELIASON
JOSEPH HAGAN
FRANK THOMSON
JEFF BENJAMIN
JOHN SUMMERS
BOB BURRICELLI
DAVE DODSON
MARK J. WETTERHAHN, ESQ.
ARTHUR H. DOMBY, ESQ.
LAWRENCE REITER
WILLIAM BRIGGS, ESQ.
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MR. WHITE: Gentlemen, my name is John White, United States Nuclear Regulatory Commission. I'm the Chief of the Reactor Projects Section 2A, Division of Reactor Projects. That is the section that is responsible for the administration of special activities at Salem and Hope Creek.

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

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

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

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

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

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

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

handling of the situation.

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

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

effect relative to this incident.

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

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

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

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

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

MR. REITER: Larry Reiter.

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

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

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

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

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

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

MR. BURRICELLI: Bob Burricelli, PSE&G.

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

MR. POLIZZI: Vince Polizzi, PSE&G.

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

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

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

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

MR. ELIASON: Okay, thank you, Mr.

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

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

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

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

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

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

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

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

unit regulators.

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

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

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

The Salem GM then initiated a contact

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Once the implications of the events

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

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

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

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

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

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

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

was not delivered.

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

The root cause of the event was -- hole

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

MR. HAGAN: Why were they --

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

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

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

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

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

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

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

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

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

won't call it an argument or a blowup.

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

MR. HAGAN: I would --

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

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

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

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

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

MR. HAGAN: Well the fact that the

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

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

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

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

MR. HAGAN: No.

MR. HOLODY: That's all.

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

MR. HAGAN: The answer is yes.

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

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

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

MR. HAGAN: That's accurate.

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

MR. HAGAN: The subsequent corrective actions will.

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

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

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

MR. LANNING: Okay.

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

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

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

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

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

MR. HAGAN: For the investigation itself, yes.

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

MR. HAGAN: Yes.

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

MR. HAGAN: Yes.

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

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

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

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

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

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

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

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

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

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

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

MR. WHITE: Yes.

MR. HAGAN: I believe it was verbal direction.

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

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

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

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

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

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

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

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

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

Salem on the 14th.

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

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

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

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

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

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

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

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

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

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

the letter that he thought had been issued to Mr. Reiter, and that that action had been consummated between Mr. Vondra and Mr. Reiter. And so he had passed that on to Mr. Miltenberger for his information.

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

MR. BURRICELLI: That's correct.

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

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

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

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

MR. HAGAN: No.

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

inappropriate for Vondra to make such a request.

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

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

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

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

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

MR. HAGAN: The incident report, yes.

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

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

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

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

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

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

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

MR. HAGAN: The normal process would be --

MR. HOLODY: What should have occurred

that day?

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

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

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

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

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

MR. HOLODY: The Ops Manager had

discussions with another individual that particular day that got -- I forget the name -- what was it, Morroni?

MR. HAGAN: Mike Morroni was the technical manager of the System Engineering/Station Engineering.

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

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

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

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

determination on operability.

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

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

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

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

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

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

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

MR. HOLODY: The Ops Manager?

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

MR. HOLODY: Who makes that?

MR. HAGAN: The Senior Shift Supervisor.

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

MR. HAGAN: Yes, yes.

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

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

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

perhaps at a higher level?

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

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

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

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

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

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

MR. HAGAN: No. No.

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

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

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

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

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

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

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

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

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

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

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

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

MR. HAGAN: I think the words that were

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

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

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

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

either this is or is not an operability problem?

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

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

MR. WHITE: That's today?

MR. BENJAMIN: That came out of this.

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

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

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

conflict of interest that was --

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

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

MR. HAGAN: Yes.

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

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

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

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

MR. LANNING: Okay.

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

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

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

MR. SATORIUS: Thank you.

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

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

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

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

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

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

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

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

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

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

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

MS. SMITH: Thank you.

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

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

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

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

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

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

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

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

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

MR. WHITE: Yeah.

MR. HAGAN: I don't know that.

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

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

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

MR. HAGAN: Are you talking near terms?

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

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

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

MR. WHITE: All right. Thank you.

MR. LANNING: Just one more question. Did Messrs. Miltenberger or LaBruna receive any counseling, letters of reprimand?

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

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

MR. LANNING: Are you going to explain why?

MR. HAGAN: In the next couple of pages.

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

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

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

Ineffective training of management personnel on safeguards afforded protected activities.

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

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

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

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

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

MR. HAGAN: Mr. Miltenberger received a

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

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

MR. HAGAN: Yes, inappropriate actions.

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

MR. HAGAN: Than what they fulfilled, right.

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

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

MR. BENJAMIN: Did you say CEO or CNO?

MR. LANNING: I thought he said CEO.

MR. HAGAN: CNO.

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

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

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

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

MR. HAGAN: Yes. Yes.

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

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

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

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

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

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

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

between your organization and management?

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

MR. WHITE: All right. Please continue.

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

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

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

management expectations.

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

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

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

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

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

intimidation.

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

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

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

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

MR. WHITE: Before you proceed there,

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

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

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

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

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

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

MR. WHITE: And why do you exonerate

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. BENJAMIN: Closer to six weeks now.

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

MR. HAGAN: And inappropriate.

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

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

MR. WHITE: Was it ineffectiveness, overall ineffectiveness?

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

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

MR. HAGAN: Yes.

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

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

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

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

MR. WHITE: Was that non-voluntary?

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

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

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

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

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

MR. WHITE: He was told that?

MR. HAGAN: He was told that.

MR. WHITE: When was he actually removed?

MR. HAGAN: February.

MR. WHITE: February '94?

MR. THOMSON: February '94.

MR. HAGAN: '94.

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

MR. HAGAN: Not that I have knowledge

of.

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

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

MR. WHITE: Anything else on Vondra?

MR. HAGAN: No.

MR. WHITE: How about Mr. Reiter?

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

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

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

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

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

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

MR. HAGAN: Mostly it involved the NSRs.

MR. OLSHAN: It was those people?

MR. HAGAN: Yes.

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

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

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

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

MR. HAGAN: Mr. Miltenberger.

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

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

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

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

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

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

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

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

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

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

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

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

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

how it's going to run?

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

MR. HOLODY: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

MR. BENJAMIN: Yes. Yes.

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

responsive and effective program.

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

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

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

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

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

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

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

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

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

MR. LANNING: In the past.

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

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

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

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

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

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

MR. BENJAMIN: Can I clarify that?

MR. LANNING: Yeah. Let me understand that.

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

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

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

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

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

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

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

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

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

I also interviewed the Onsite Safety

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. SATORIUS: Thank you.

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

exactly the best. How would you characterize it?

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

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

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

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

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

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

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

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

organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. LANNING: Amor; ourselves?

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

MR. LANNING: Okay.

(Brief recess.)

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

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

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

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

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

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

MS. SMITH: That was the question.

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

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

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

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

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

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

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

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

MS. SMITH: Thank you.

MR. WHITE: Any other questions? Dan,

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

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

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

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

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

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

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

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

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

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

(Proceedings closed.)

CERTIFICATION

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

LORETTA B. DEVERY, RPR

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