Salem & Hope Creek Update Agenda
November 14, 2003

binny
- non-conservative decision making
- production over safety
- union pressure

Agenda Package Contents:
1) Update Agenda
2) Attachment A (Interview/Assessment Status Table)
3) Attachment B (Regulatory Action Schedule)
4) Attachment C (Background/Chronology)
5) Attachment D (External Q&As)

1.	ANY EVIDENCE OF UNSAFE OPERATION? NO Operating review of Salem & Hope Creek - No recent reports to NRC or events
2.	Allegations Status - Review interview progress & results (Attachment A)
3.	Upcoming Regulatory Operations - Review schedule (Attachment B)
4.	Follow-up Items
	a) Explore conduct of operations aspects of issue #4 ([redacted] operating the Feedwater valve)
done	b) Revise Att. A format to include a column indicating whether the issue listed is a technical violation or wrongdoing (50.5 Deliberate Misconduct ... willful or careless disregard ...) as well as a brief statement of status - add - IR - Inspectors awareness
	c) Keep External Q&A's up-to-date ... ready for distribution if/when the issues go public
	d) state court case w/ deter

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on-going
- Assess what we have so far
- tech & SWT
- From SM interviews in by 12/15/03

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NRC ASSESSMENT OF SIGNIFICANT SALEM/HC ALLEGATION

	Discreet Issue / Event (Derived directly from 2003-0110)	NRC Assessment (Including Interview results)	Technical Violation?	Wrong-doing?
1	March 17, 2003 at Hope Creek - [redacted] confide that [redacted] pressured for restart without forced outage - bypass valve incident; Forced outage & turbine bypass valve (TBV) repair occurred.	Interviews to date have suggested that the concern here was betwee[redacted] and his department heads. He apparently "harassed" (From interviews with [redacted] them for four hours on why a shutdown to repair a TBV was necessary when all of the department heads believe the decision to shutdown was a "no brainer". Although non-conservative decision making is a possible root cause, there was no TS violation.	No	N/A
2	March 17, 2003 at Hope Creek - [redacted] told alleger he did not have the authority to stop the evolution (reactivity excursion during the bypass valve shutdown?) even though he knew it was ill-conceived.	Not yet developed - More to follow	No	N/A
3	June 17, 2003 at Hope Creek - EDG leakage exceeds LCO time; pressure to avoid shutdown; [redacted] directed operator [redacted] to not shutdown; shutdown commenced within acceptable time frame and met regulations.	Interviews to date have suggested that there was time pressure to delay the shutdown as long as possible to allow engineering time to come up with an adequate operability justification. Although non-conservative decision making was a possible root cause, there was no TS violation. The HC RIs were fully engaged with the issue as it unfolded.	No	N/A
4	Sept 24, 2002 at Salem [redacted] ECR confidential report substantiates allegation, Third Step Grievance.	Interviews to date have suggested that this industrial safety issue may have been substantiated. Many NEOs noted that the [redacted] went and the field and [redacted] without: an NEO to operate the valve, wearing the necessary personal safety gear, and without following the work control process. Although this issue may have been substantiated and non-conservative decision making was a possible root cause, this is not a an NRC regulated issue.	No	N/A
5	Fall (?) 2002 at Salem - Manager [redacted] directed SRO [redacted] to NA a startup checklist step. [redacted] tried to have [redacted] fired but was unsuccessful.	New information received on November 6, indicates this alleged activity may have actually occurred when [redacted] directed [redacted] to "NA" a surveillance step for the Reactor Vessel Vent valves when a single valve indicated dual indication during this routine stroking evolution. [redacted] was allegedly told by the Operation Crew that they would not "NA" the step. Earlier information from interviews suggested that the concern involved "NA-ing" a second verification containment walkdown to be done by a VP-OPS level person step. This step was added to the SU procedure as a lessons learned from the Davis-Besse issue. According to [redacted] this walkdown was actually done by himself and [redacted] and startup was delayed by a day because of leaks that they found from some SG wet layup level indication valves. So, the step was actually completed contrary to the alleger's assertion.	No	N/A

	Discreet Issue / Event (Derived directly from 2003-0110)	NRC Assessment (Including Interview results)	Technical Violation?	Wrong-doing?
6	Salem grassing approach (i.e., heroic efforts) deviated from expected approach / lessons learned from 1994 grassing [redacted] Unit had eventually go offline - alleger caught him before plant was shutdown	[redacted] stated that he was the [redacted] during grassing season and would not have supported any efforts to station additional operators in the intake to clean the screens during heavy grassing periods. His approach would have been to take the unit offline. He indicated that he may have told the alleger that he was concerned that some of the outage staff would have chose to augment screen cleaning with operators vice shutting down the unit.	No	N/A
7	Higher Tritium sample concentration in Spring 2003 - a serious issue that had to be handled with kid gloves to keep us [PSEG] out of trouble" [redacted] SFP leakage	[redacted] indicated during the interview that he was not in a role in RP at the time this issue was being developed but he did recall having conversations with PSEG communications people on how to handle the issue. He said he may have discussed this with the alleger. The NRC has a great deal of information on this issue that has been derived from inspection activities including numerous face-to-face interactions between inspectors and PSEG managers and staff.	None from this allegation	N/A
	Excessive use of temporary logs	Not yet developed - More to follow	TBD	TBD
	Salem 2 ISI relief request re: piping UT (coverup?)	Not yet developed - More to follow	TBD	TBD
	HC offgas issue after [redacted] took over. Rad safety concerns expressed but not resolved	[redacted] indicated some knowledge of this issue since he believe it pertained to elevated HC offgas flow rates due to excessive air in-leakage into the condenser. He indicated that [redacted] wrote a somewhat inflammatory notification because the NEOs had to try to identify the location of the leak in higher than normal radiation fields. The location of the leak eventually was discovered and the offgas leakage reverted to its pre-in-leakage levels.	No	N/A
	HC employee allegedly asked to modify a Notification re: "in-leakage" [redacted] - elevated offgas - higher than normal N16 - needed to go in to find leak - were getting dose during visits to find the leak.	[redacted] indicated some knowledge of this issue since he believe it pertained to elevated HC offgas flow rates due to excessive air in-leakage into the condenser. He indicated that Souber wrote a somewhat inflammatory notification because the NEOs had to try to identify the location of the leak in higher than normal radiation fields. The location of the leak eventually was discovered and the offgas leakage reverted to its pre-in-leakage levels.	No	N/A

	Discreet Issue / Event (Derived from Interviews)	NRC Assessment (Including Interview results)	Technical Violation?	Wrong-doing?
1	PSEG decision making relative to #14 Steam Generator (SG) Feed Regulating Valve (FRV) believed to be stuck at 74% open	Interviews to date have suggested that this concern related primarily to the timing of a decision to enter TS 3.0.3. An NEO and RO have asserted that it should not have taken 12 hours to enter 3.0.3. However, once the licensee's troubleshooting plan showed that FRV was stuck they immediately entered the LCO and followed the SD requirements. Although non-conservative decision making was a possible root cause, there was no TS violation.		
2	In the Spring 2001 outage, a Salem Unit 1 reactor trip was caused by a main generator current transformer failure. The [redacted] told operations that they needed to get the reactor started up by particular date or their NRC performance indicator was going to "go white." [redacted] allegedly harassed operations daily by asking day "when are you going to start the plant". Operations then told [redacted] they would start up when they thought they were within a day of putting steam into the main turbine. Although [redacted] insisted that operations should start up the reactor with the MSIVs shut, operation refused to do so because it was contrary to their safety analysis.	Not yet developed - More to follow		

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Salem & Hope Creek Schedule

Week of:	Activities	When
Nov. 3rd	Larry Scholl Special Inspection Onsite/Debrief	All week
	Status/Update Briefing	Nov. 7th 10:00am
Nov. 10th	Inspection Reports Issued	Nov. 11th
Nov. 17th	Status/Update Briefing	Nov. 17th 9:30am
	3rd Quarter Assessment Meeting	Nov. 17th 1:30pm
Nov. 24th	Hope Creek Operator Licensing Meeting	Nov. 24th 9:30am
	Supplemental Inspection Exit ?	
	Special Inspection Exit ?	
Dec. 1st	Status/Update Briefing	Dec. 1st 1:30pm
Dec. 8th	Site Visit (9th & 10th ? ... 1 day ?)	

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Salem/Hope Creek Allegation Background/Chronology

Issue/Event Date	Description
Not Specified	Excessive use of temporary tags
Not Specified	Salem 2 In-service Inspection (ISI) relief request re: piping UT (coverup?)
Not Specified	Hope Creek offgas issue after [redacted] took over. Rad safety concerns expressed but not resolved
Not Specified	Hope Creek employee allegedly asked to modify a Notification re: "in-leakage"
Spring 2001	In the Spring 2001 outage, a Salem Unit 1 reactor trip was caused by a main generator current transformer failure. The [redacted] told operations that they needed to get the reactor started up by a particular date or their NRC performance indicator was going to "go white." [redacted] allegedly harassed operations daily by asking day "when are you going to start the plant". Operations then told [redacted] they would start up when they thought they were within a day of putting steam into the main turbine. Although [redacted] **insisted that operations should start up the reactor with the MSIVs shut**, operations refused to do so because it was **contrary to their safety analysis.**
Spring 2002	**Salem grassing approach (i.e., heroic efforts) deviated from expected approach / lessons learned from 1994 grassing** [redacted] This concern relates to a decision to keep one of the Salem unit's on during a period of heavy grassing. Interviews have suggested that this may have been done for one day, but when it occurred on a second day the unit was taken off-line.
Sept. 24th, 2002	Based on the size and location of a significant steam leak (20' to 40' plume from the bonnet of a Feed Water Pump steam admission valve), [redacted] agreed with the shift operators that the plant should be shut down to affect repairs. [redacted] left to speak with "upper management" and, upon his return, subsequently [redacted] which isolated the steam leak avoiding a shut down. [redacted] confidential report substantiates allegation, Third Step Grievance [redacted] **operated the valve without regard to his own personal safety, without a Nuclear Equipment Operator (NEO), and without the permission/knowledge of control room personnel).**
Fall 2002	Manager [redacted] directed an SRO [redacted] to **NA a startup checklist step.** [redacted] tried to have [redacted] fired but was unsuccessful. Information received indicates this alleged activity may have actually occurred when [redacted] directed [redacted] to **"NA" a surveillance step for the Reactor Vessel Vent valves** when a single valve indicated dual indication during this routine stroking evolution. [redacted] was allegedly told by the Operation Crew that they would not "NA" the step. Earlier information from interviews suggested that the concern involved "NA-ing" a second verification containment walkdown to be done by a VP-OPS level person step. This step was added to the SU procedure as a lessons learned from the Davis-Besse issue. According to [redacted] this walkdown was actually done by himself and [redacted] and startup was delayed by a day because of leaks that they found from some SG wet layup level indication valves. So, the step was actually completed contrary to the alleger's assertion.
Nov. 2002	**Higher Tritium sample concentration in Spring 2003 - "a serious issue that had to be handled with kid gloves to keep us [PSEG] out of trouble"** [redacted]

Salem/Hope Creek Allegation Background/Chronology

Issue/Event Date	Description
March 17th, 2003	1. **Hope Creek Reactivity Event** - Manipulation of Electro Hydraulic Control (EHC) system caused an **unanticipated rise in reactor power 6 ½ % to 13 % ...** not discovered until Wednesday (3/19/03). 2. Entering a planned shutdown to repair **3 technical/mechanical failures** (late Sunday / early Monday morning). 3. Monday morning (0800) Turbine Bypass Valve (TBV) stuck open (47%). TBV closed fully during subsequent testing. [redacted] argued with [redacted] about whether or not a shut down was required. The concern here was between [redacted] and his department heads. He apparently **"harassed"** (from interviews with [redacted] **them for 4 hours on why a shutdown to repair the TBV was necessary** when all of the department heads believed that shutting down was a "no brainer". Although non-conservative decision making is a possible root cause, there was no TS violation. 4. Heated discussions about the duration of the forced outage.
June 17th, 2003	**Hope Creek - EDG leakage exceeds LCO time; pressure to avoid shutdown;** [redacted] directed operator [redacted] to not shutdown; shutdown commenced within acceptable time frame and met regulations. There was time pressure to **delay the shutdown** as long as possible to **allow engineering time to come up with** an adequate operability **justification.** Although non-conservative decision making was a possible root cause, there was no TS violation. The HC RIs were fully engaged with the issue as it unfolded.
Sept. 3rd&4th, 2003	Initial allegation contact between RI-2003-A-0110 alleger & Dave Vito.
Sept. 5th, 2003	Alleger **informed of right to file** a discrimination **complaint with** the Dept. of Labor **(DOL).**
Sept. 9th, 2003	**Initial** recorded **interview** with alleger & **1st Allegation Review Board (ARB).**
Sept./Oct. 2003	PSEG decision making process relative to #14 Steam Generator (SG) **Feed Regulating Valve (FRV) believed to be stuck at 74% open.** This concern related primarily to the **timing of a decision to enter TS 3.0.3.** An NEO and RO have asserted that it should not have taken 12 hours to enter 3.0.3. However, once the licensee's troubleshooting plan showed that FRV was stuck they immediately entered the LCO and followed the SD requirements. Although non-conservative decision making was a possible root cause, there was no TS violation.
Sept. 25th, 2003	**Interviews conducted Sept. 25th through Oct. 9th** [redacted]
Sept. 29th, 2003	**Alleger filed civil discrimination law suit** against PSEG in Morris County, N.J.
Sept. 30th, 2003	Alleger sends a **letter**, via email, **to** the NRC, Region I, **Regional Administrator** indicating that the [redacted] thought that **issues at the site "aren't going to be brought up ... just like Davis-Besse."**
Oct. 2nd, 2003	**2nd ARB**
Oct. 9th, 2003	More email received from alleger.
Oct. 11th, 2003	More email received from alleger.
Oct. 14th, 2003	**Interviews conducted Oct. 14th through Oct. 21st** [redacted]

Salem/Hope Creek Allegation Background/Chronology

Issue/Event Date	Description
Oct. 16th, 2003	Certified acknowledgment letter sent.
Oct. 22nd, 2003	Interviews conducted on Oct. 22nd [redacted]
Oct. 23rd, 2003	Interviews conducted on Oct. 23rd [redacted]
Oct. 24th, 2003	Interviews conducted Oct. 24th through Oct. 29th [redacted]
Oct. 28th, 2003	3rd ARB
Nov. 4th, 2003	Interviews conducted Nov. 4th through Nov. 7th [redacted]
Nov. 7th, 2003	4th ARB
Nov. 12th, 2003	Interviews conducted Nov. 12th and Nov. 13th [redacted]
Nov. 13th, 2003	5th ARB

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