

# Salem & Hope Creek Update Agenda

## November 7, 2003

1. 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
    - None
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Information in this record was deleted  
in accordance with the Freedom of Information  
Act, exemptions 7C  
FOIA-2005-0194

R-136

- Tech V. 2  
- w/p  
- Work left to do?

Keep Q & A as living document

7c

## NRC ASSESSMENT OF SIGNIFICANT SALEM/HC ALLEGATION

	Discreet Issue / Event (Derived directly from 2003-0110)	NRC Assessment (including interview results)	Interviews left to do
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 between [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. - mty [redacted] Direct reports - intimidating - no safety issue - report they was done eventually	2/5
2	March 17, 2003 at Hope Creek - [redacted] told allegor 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	4/4
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.	

	Discreet Issue / Event (Derived directly from 2003-0110)	NRC Assessment (including interview results)	Interviews left to do
4	Sept 24, 2002 at Salem - [REDACTED] operates [REDACTED] ECP 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.	Plant Ops Procedure Control of the activity?
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 allegor's assertion.	1/3
6	Salem grassing approach (i.e., heroic efforts) deviated from expected approach / lessons learned from 1994 grassing [REDACTED]	Interviews to date have noted that grassing at Salem is a long standing problem that is well known by all levels of staff and management and that it challenges the existing equipment designed to cope with the grassing. 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.	
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]	Not developed during Interviews. However, 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.	??

Discreet Issue / Event (Derived directly from 2003-0110)	NRC Assessment (including interview results)	Interviews left to do
Excessive use of temporary logs	Not yet developed - More to follow	
Salem 2 ISI relief request re: piping UT (coverup?)	Not yet developed - More to follow	
HC offgas issue after [REDACTED] took over. Rad safety concerns expressed but not resolved	Not yet developed - More to follow	
HC employee allegedly asked to modify a Notification re: "in-leakage"	Not yet developed - More to follow	

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Discreet Issue / Event (Derived from Interviews)	NRC Assessment (including interview results)	Follow-up Interview ?
<p>1 PSEG decision making relative to #14 Steam Generator (SG) Feed Regulating Valve (FRV) believed to be stuck at 74% open</p>	<p>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.</p>	
<p>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.</p>	<p>Not yet developed - More to follow</p>	

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*Robert 1st new ally  
Wait for transcript &  
determine whether to  
open?*

## Salem & Hope Creek Schedule

Week of:	Activities	When	
Nov. 3 <sup>rd</sup>	Larry Scholl Special Inspection Onsite/Debrief	All week	
	Status/Update Briefing	Nov. 7 <sup>th</sup>	10:00am
Nov. 10 <sup>th</sup>	Inspection Reports Issued	Nov. 11 <sup>th</sup>	
	3 <sup>rd</sup> Quarter Assessment Meeting/VTC	Nov. 14 <sup>th</sup>	
	Senior Regional Management Briefing		
	Supplemental Inspection Exit ?		
Nov. 17 <sup>th</sup>	Status/Update Briefing	Nov. 21 <sup>st</sup>	
	Special Inspection Exit ?		
Nov. 24 <sup>th</sup>	Hope Creek Operator Licensing Meeting	Nov. 24 <sup>th</sup>	9:30am
	Senior Regional Management Briefing		
Dec. 1 <sup>st</sup>	Status/Update Briefing		
Dec. 8 <sup>th</sup>	Site Visit (9 <sup>th</sup> & 10 <sup>th</sup> ? ... 1 day ?)		

Appendix B

*Draft*

The following Salem/HC Issues were derived from interviews. They do not constitute safety issues, but are reflective of slow corrective actions, operator workarounds, or may have been caused by schedule pressures or weak follow through by engineering, maintenance or operations personnel and management.

No	Technical/Workaround/Schedule Pressure issues	Source
1	The Salem Boric Acid Tank Installed Level Device has been replaced with a piece of tygon tube. This is a long standing workaround that indicated slow corrective action and a willingness to live with problems.	11/6 interview
2	The SW discharge xconnect valves (SW-17) have significant seat leakage that challenges the #2 & #4 bay installed and temporary sump capability during surveillance testing	11/6 interview
3	The Salem Unit 3 Starting Air compressors are totally unreliable. A N2 tank truck is on-site to backup the compressors when they fail. This is a long standing workaround that indicated slow corrective action and a willingness to live with problems.	11/6 interview
4	Prior to INPO arriving in the spring of 2003, EMIS tags were removed from plant equipment.	11/6 interview
5	During a hurried attempt to fill a SW loop, an NEO was put into an unsafe condition under the Salem Unit 2 RAP tanks. Looking for boundary valve leakage with extension cords and high intensity lights in the area.	11/6 interview
6	A drain tank installed for 15 CFCU at its containment penetration to collect known leakage filled up and is dripping on ductwork. This is a known problem that needs more attention.	11/6 interview