

This article is a "rewrite" of the article "Shuttle Report Blames NASA Culture" that was published on the [msn.com](http://msn.com) website on 8/26/03. It represents concerns for where we could be headed at PSEG Nuclear without the NRC's intervention. Please read it for insight into the issues plaguing PSEG Nuclear that, if not addressed, could lead to a tragic nuclear event.

## NRC report blames PSEG Nuclear's 'broken safety culture'

MSNBC STAFF AND WIRE REPORTS

WASHINGTON, 10/01/03 — PSEG Nuclear's habit of relaxing safety standards to meet financial and time constraints set the stage for the country's most significant nuclear safety incident since TMI. Nuclear Regulatory Commission's independent Accident Investigation Board investigators said Friday. They asserted the company's "broken safety culture" led to the tragedy.

IN A WIDE-RANGING analysis of decades of PSEG Nuclear history, the Accident Investigation Board said the company's attitude toward safety hasn't changed much since the TMI incident or since the Salem Generating Station was shut down in the

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early 1990s.

The site lacks “effective checks and balances, does not have an independent safety program and has not demonstrated the characteristics of a learning organization,” the board said in a stinging 248-page report.

“Because the board strongly believes the company had repeated opportunities to address these persistent, systemic flaws and did not, the decision was made to revoke PSEG’s operating license,” the report said.

Retired NRC Commissioner Shirley Jackson, the independent investigation board’s chairman, told reporters at a Washington briefing that PSEG tends to follow safety procedures diligently at first, then “morph or migrate away” from that diligence as time goes on.

“The history of PSEG indicates that they’ve done it before,” Jackson said.

#### **AN ‘ECHO’ OF RESTART YEARS**

In addition to detailing the technical factors behind the nuclear reactor incident, the board’s report laid out the cultural factors behind PSEG Nuclear’s failings. It said, due to fears of retaliation and reprisals, people at all levels of the organization were afraid to speak up about safety issues. The report sites hundreds of complaints in the company’s Employee Concerns files that have been logged but unresolved.

In addition, site managers fell into the habit of accepting as normal some flaws in the safety systems and tended to ignore or not recognize that these problems could foreshadow catastrophe. This was an “echo” of some root causes of the Salem Generating Station shut down nearly 10 years ago,” the board said.

“These repeating patterns mean that flawed practices embedded in PSEG’s organizational system continued for many years at a time when others in the nuclear industry were dramatically improving their safety and management practices,” the report said.

#### **‘INEFFECTIVE LEADERSHIP’**

But most of all, the report noted, there was “ineffective leadership” that “failed to fulfill the

implicit contract to do whatever is possible to ensure the safety of the public, the employees, the environment.”

Management techniques in PSEG, the report said, discouraged dissenting views on safety issues and ultimately created “blind spots” about the risks the were increasing.

Throughout its history, the report found, “PSEG has consistently struggled to achieve viable safety programs” but the company effort “has fallen short of its mark.”

#### **‘SAFETY LOST OUT’**

Maj. Gen. John Barry, a member of the board, told journalists that PSEG’s safety mission has conflicted with the goals of reducing costs and meeting flight schedules. “Unfortunately, safety lost out,” he said. Barry explained that when PSEG Power, comprised largely of non-nuclear experienced people, assumed “control” of PSEG Nuclear and thus dictated operating decisions, “the hand-writing was on the wall. People without the background, education, or experience to do so were calling the shots and giving orders. Too often NRC-licensed operators found it necessary to defy such orders. On the day of the incident, the Operations Manager and Assistant Operations Manager were both off-site and could not intervene when the latest call came in to the Control Room: “Find a way to stay on-line,” PSEG Power President Frank Cassidy is reported to have said. The operators followed his directive and the cascade of events that led to the tragedy was in play.

#### **CHAIRMAN AND CORPORATE OFFICERS SHARE BLAME**

“The highest levels of the PSEG Enterprise exerted pressure to reduce or at least freeze operating costs and to do everything possible to increase revenues,” the report said. As a result, “safety and support upgrades were delayed or deferred, and safety system infrastructure was allowed to deteriorate.”

At another point, the report noted: “Little by little, PSEG was accepting more and more risk in order to stay on line and make more money.” Also: