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REPORT OF INTERVIEW
OF
[REDACTED]

On October 26, 2003, [REDACTED] was interviewed under oath at the Salem/Hope Creek facility by the Reporting Agent (RA), Nuclear Regulatory Commission (NRC), Office of Investigations (OI), Region I. He is currently employed as a [REDACTED] and has been in that position since [REDACTED]. He worked on-site since [REDACTED]. [REDACTED] also serves as a [REDACTED]. A tape recording was made of the interview. Also present for the interview was [REDACTED]. The subject of the interview was the assessment of the safety conscious work environment at Salem/Hope Creek. The following information, in substance, was reported by [REDACTED].

He believes that employees use the notification system to document concerns and problems they find as appropriate. He believes the thought may cross someone's mind to wonder what their boss might think if they write document an issue. He considers it a "human nature" type of concern and said it would come into the thought process, but people document the problems they find. Over the years people have come to him to ask him to "lead up this cause." He did not call it "frequent", but it happens every once in a while. He attributes that to the possibility that they had a fear of the supervisor's being mad and taking some kind of retribution at some point. [REDACTED] then handles the issue or sees that the steward on the appropriate shift understands someone has a problem and ensures it gets follow through. He personally feels he can raise concerns on any valid issue by bringing it up to supervision and by putting in a notification.

[REDACTED] gave an example of March 31, 2003, off-gas issue as a nuclear safety concern. [REDACTED] concern was that the [REDACTED] he relieved were not happy due to off-gas being above 75 cfm. Procedures were out and being checked and the UFSAR indicated that they were outside of the design basis of the plant. The NCOs indicated they did not get a good response from their supervisor; they did not believe it was getting the attention they thought it deserved. [REDACTED] got involved to try to push the issue. Based on the information he had at the time, [REDACTED] believed they were outside of their design and the plant should be shut down. He told this to [REDACTED] and [REDACTED]. These supervisors understood it was an issue and a TARP team was looking at it. At that time, [REDACTED] believed the plant should be shut down based upon all the information he had in front of him. He presented a [REDACTED] to [REDACTED]. [REDACTED] responded that it did not need to be a [REDACTED] was adequate. That left him with the impression that his concern was not taken as seriously as it should be. [REDACTED] gave impression that he agreed they were outside of design, but he did not hear [REDACTED] say the plant should be shut down. [REDACTED] also called him that night to ask what his concern was and indicated they were looking into it. Ultimately, an engineering evaluation decided that flow could go to 150 cfm, based upon the design for two plants. The procedure was changed four days later to indicate that they could operate above 75 cfm. [REDACTED] claimed that if that had been stated at 6:00PM that night, [REDACTED]. (He does not believe he suffered any criticism or adverse actions for pushing the issue [REDACTED].) He described this as the most

stressful situation he could recall because he believed they needed to shut the plant down and does not recall any situation equal to that.

The only instance he felt was production over safety was the off-gas issue he discussed. This is because he did not think it was understood by supervision at the time [REDACTED] that engineering was going to come to that conclusion. He opined that some of the supervisors do not have enough experience and rely on their bosses. He believes [REDACTED] had to rely on the TARP team, other people that do not have the license responsibility to run the plant. In this instance, it may have involved [REDACTED]. He pointed out that [REDACTED] was no longer there and with [REDACTED] there now, he has more experience.

[REDACTED] offered an example of equipment issues that were not categorized properly by the SROs. He believed it was around June 2003, there were diesel jacket water leaks and environmental conditions from diesel fumes. The concern was what other gases, apart from CO, could be causing problems. He believed it was beyond the normal duties of an operator to run the diesels with SCBA. [REDACTED] and [REDACTED] explained that three people got sick over this and it should not have taken as long as it did to get fixed. SCBA came up because it [REDACTED] said that would be what it would take to get him to go into the room. Supervision interpreted that to say the union said it was OK to work with SCBA. They do not know how this became twisted, but it came out after their meeting with [REDACTED] and the industrial hygienist who later discussed it with other supervision. Further, [REDACTED] heard that it was not A shift's choice to use SCBA, but they feared for their jobs. The LCO time limit affected this in that they wanted the plant declared operable to keep the plant running. He thought people freely wrote numerous notifications about this. He acknowledged there are "certainly" schedule and production pressure because it "is a business."

He thought there may be more examples, not of the magnitude of the off-gas issue, but the individuals on [REDACTED] shift (C) could be asked. [REDACTED] thinks numerous people believed the diesel issues in June 2003 was a production over safety issue because they believed it was inoperable. [REDACTED] were involved in this event. [REDACTED] recalled having a discussion with [REDACTED] who told him they found they could do the repair in less time to fit the 72 hour window, however they did not have the parts. This disturbed him because they knew for months they had a problem. Nobody, including the company, was happy with the handling of this issue at all. [REDACTED] thought there may be more examples of production pressures, but none were coming to mind.

Asked if there were any strengths in the safety culture, [REDACTED] responded that on every shift they have a shift safety representative for the union. He likes to think that prevents people from being pressured and it gives them someone to go to to see if the right thing is being done. He mentioned an industrial safety near-fatal accident in February or March 2001. After this event, there was a step-change in personal safety due to this incident. [REDACTED] thinks the focus has remained with them on working safely. He stated that the safety representatives sometimes experience pressure from supervision. He gave an example involving [REDACTED] and a switchyard issue that occurred in the last two weeks. The

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interlocks prevent contact with live wires and [REDACTED] wanted to bypass the interlock to continue with switching and finish the tagging release to restore a breaker. [REDACTED] said they would not and there was a lot of discussion and pressure, reportedly from [REDACTED], to get [REDACTED] to try to do it. [REDACTED] had nothing further to offer regarding pressure on the safety representatives.

[REDACTED] noted as a strength in the work environment that he believes people do identify problems and write notifications. A weakness would be the experience level in running the plant with some of the shift managers. In his opinion, [REDACTED] and [REDACTED] are negatively affected in their performance because of this. Additionally, instead of the key phrase "conservative decision", "acceptable risk" or "risk assessment", are used more in the last year and a half. He attributes that to deregulation.

[REDACTED] provided copies of the logs and notifications regarding the off-gas issue (attached).

Reported by:

Eileen Neff, Special Agent
Office of Investigations
Field Office, Region I

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