REPORT OF INTERVIEW
OF
GILBERT JOHNSON

On January 7, 2004, Gilbert JOHNSON, Operation Engineer, U.S. Nuclear Regulatory Commission (NRC), Region I, was interviewed by the Reporting Agent (RA), NRC, Office of Investigations (OI), Region I. JOHNSON was contacted in regard to his reported conversation (see attached email dated January 5, 2004) with Hope Creek Station (HC [redacted] regarding the reactivity event at HC in March 2003. The following information, in substance, was reported by JOHNSON:

He was assigned during the first week of April 2003 to administer Limited Senior Reactor Operator (LSRO) examinations for fuel handling at HC. JOHNSON assisted in the administration of examinations for t[redacted] He was aware that HC had recently experienced a reactivity event and he was interested in how that would affect the requalification training for the licensed personnel.

[redacted] JOHNSON that he was on shift when the reactivity transient occurred. The issue involved the shift's wanting to change the turbine pressure controller while the reactor was critical. [redacted] shift was given a procedure the day before the evolution was to occur. They did a single "dry run" in the simulator and identified changes needed in the procedure. The procedure was sent back; [redacted] did not identify specifically who developed and addressed the changes in this procedure. The procedure was returned to Operations with the requested changes. [redacted] thought there should have been another dry run conducted, but indicated that time and schedule pressure did not allow it and they had to "get on with it." JOHNSON inferred from this discussion that the pressure was to return to full power. They ran the procedure and had problems because the procedure did not address all the issues that occurred when it was implemented. [redacted] did not identify by name any of the other individuals associated with this event.

JOHNSON did not believe that regulatory requirements required a second dry run in this instance, but described it as an Infrequently Performed Evolution (IPE), and explained that it required heightened management oversight.

[redacted] told him that he was reprimanded for his failure to recognize the reactivity event and [redacted] had no issues with that reprimand. JOHNSON believed the reprimands would have primarily been focused on the shift and control room supervisors for their reported failure to recognize the reactivity event.

JOHNSON thought further about [redacted] comments and discussed them with NRC Allegation Coordinator Dave VITO the next day. Based upon their discussion, JOHNSON telephoned [redacted] on the same day to ask if he had approached him (JOHNSON) as a regulator in discussing the event. [redacted] advised that he was simply answering JOHNSON's questions and not submitting an allegation. JOHNSON explained that after he recently became involved in reviewing interviews for the ongoing inspection at Salem/HC

regarding the safety culture, this incident came to mind.

Reported by:

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

EPW

Case No. 1-2002-042

From: Gilbert Johnson
To: Exn1
Date: 1/5/04 6:57AM
Subject: Person I spoke to at HC relative to management pressure

Although I am not 100% sure, both Alan Blamey and I recall that [redacted] was the most likely person that related to me that they had pressure to "get on with it" the day they had the reactivity issue. He would have been the [redacted]n that shift.

Anything more I can do?