

# Salem/Hope Creek Allegation Background/Chronology

Issue/Event Date	Description
Feb. 18 <sup>th</sup> , 2004	10 <sup>th</sup> ARB
Feb. 17 <sup>th</sup> , 2004	<u>Interviews conducted between Feb. 2<sup>nd</sup> and Feb. 17<sup>th</sup></u> <div style="background-color: black; width: 100%; height: 80px; margin-top: 5px;"></div> <span style="float: right; font-size: 2em;">7C</span>
Feb. 11 <sup>th</sup> , 2004	1 <sup>st</sup> ARB for "Spin-Off" Allegation (#20040010 ... Conduct of Maintenance Issues)
Jan. 29 <sup>th</sup> , 2004	9 <sup>th</sup> ARB
Jan. 28 <sup>th</sup> , 2004	Issued a "significant letter" to PSEG providing them with interim results of our ongoing SCWE review (they have until February 27 <sup>th</sup> to respond with an action plan).
Jan. 28 <sup>th</sup> , 2004	<u>Interviews conducted between Jan. 7<sup>th</sup> and Jan. 29<sup>th</sup></u> <div style="background-color: black; width: 100%; height: 150px; margin-top: 5px;"></div>
Jan. 27 <sup>th</sup> , 2004	Initial interview with "Nine Mile Spin-Off Allegor"
Jan. 8 <sup>th</sup> , 2004	8 <sup>th</sup> ARB
Dec. 31 <sup>st</sup> , 2003	<u>Interviews conducted between Dec. 2<sup>nd</sup> and Dec. 31<sup>st</sup></u> <div style="background-color: black; width: 100%; height: 100px; margin-top: 5px;"></div>
Dec. 18 <sup>th</sup> , 2003	7 <sup>th</sup> ARB
Nov. 17 <sup>th</sup> , 2003	6 <sup>th</sup> ARB
Nov. 13 <sup>th</sup> , 2003	5 <sup>th</sup> ARB
Nov. 12 <sup>th</sup> , 2003	<u>Interviews conducted Nov. 12<sup>th</sup> and Nov. 13<sup>th</sup></u> <div style="background-color: black; width: 100%; height: 40px; margin-top: 5px;"></div>
Nov. 7 <sup>th</sup> , 2003	4 <sup>th</sup> ARB <div style="background-color: black; width: 100%; height: 20px; margin-top: 5px;"></div> <p style="text-align: center;">(follow-up re documentation to provide)</p>

Information in this record was deleted  
in accordance with the Freedom of Information  
Act, exemptions 7C  
FOIA- 2005-0194

R-12



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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. 9 <sup>th</sup> , 2003	Initial recorded interview with allegor & <u>1<sup>st</sup> Allegation Review Board (ARB)</u> .
Sept. 5 <sup>th</sup> , 2003	Allegor informed of right to file a discrimination complaint with the Dept. of Labor (DOL).
Sept. 3 <sup>rd</sup> & 4 <sup>th</sup> , 2003	Initial allegation contact between RI-2003-A-0110 allegor & Dave Vito. <span style="float: right;">7C</span>
June 17 <sup>th</sup> , 2003	<b>Hope Creek - EDG leakage exceeds LCO time; pressure to avoid shutdown;</b> [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.
March 17 <sup>th</sup> , 2003	<ol style="list-style-type: none"> <li>1. <b>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).</b></li> <li>2. Entering a planned shutdown to repair 3 technical/mechanical failures (late Sunday / early Monday morning).</li> <li>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.</li> <li>4. Heated discussions about the duration of the forced outage.</li> </ol>
Mar. 28 <sup>th</sup> , 2003	Allegor's last day on site (employment officially terminated this date).
Mar. 26 <sup>th</sup> , 2003	Allegor told (by the [redacted]) that the [redacted] and the [redacted] wanted the allegor "out by Friday" (March 28 <sup>th</sup> , 2003).
Mar. 25 <sup>th</sup> , 2003	Allegor submitted letter to [redacted] reiterating work environment concerns and describing the alleged retaliatory actions.
Feb. 26 <sup>th</sup> , 2003	Allegor met with former [redacted] to purportedly discuss [the] bonus. But, after discussing concerns about the work environment at Artificial Island, the allegor was informed of future termination (originally planned for April 16 <sup>th</sup> ). It was also alleged that the former [redacted] then directed that the termination be "accelerated."
Nov. 2002	<b>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"</b> [redacted]

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Fall 2002	<p>Manager [redacted] directed an [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 allegor's assertion. <span style="float: right;">7C</span></p>
Sept. 24 <sup>th</sup> , 2002	<p>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), the [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] ECP confidential report substantiates allegation, Third Step Grievance [redacted] without regard to his own personal safety, without a Nuclear Equipment Operator (NEO), and without the permission/knowledge of control room personnel).</p>
Spring 2002	<p>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.</p>
Spring 2001	<p>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.</p>
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"

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