September 4, 2003 via facsimile

7C

1. At a PSEG Nuclear management team meeting on 1.10.03 for which I have hand-written notes [redacted] said the following regarding comments on Corporate Safety Culture survey results: "We used to care and now we don't—that's what people tell us. We say stuff [about safety]. People don't believe it. The survey shows we don't care. If we cared about safety, what would it look like?"

Question for the NRC:

If a CNO is saying this to and about his management team, should the facility be operating?

2. The following three-page document [entitled "January Flawless Execution, February Flawless Execution, Thinking/Themes"] shows events that happened at Salem and Hope Creek in January and February, 2003. [Handwritten notes are those of Operations Director]. This list and the statements on page three were compiled by [redacted]. He used this as a hand-out at an early-March meeting with management team members. Especially note item 7 that says *"We don't know how to practice or apply safety to our work."*

7C

Question for the NRC:

If a Nuclear Vice President is saying this to and about his management team, should the facility be operating?

3. I, frankly, was hoping that things would significantly improve once [redacted] was no longer [redacted] However, in notable areas, improvements have not been the case.

7C

A Hope Creek Operations Superintendent stated that he and his Operations Manager had to choose to **not** follow an instruction (but not a direct order) by the Director of Operations to **not** commence plant shut-down when nearing the end of a 72-hour LCO (for A or B diesel generator jacket water leak). Against the direction provided by the Director of Ops, reactor power was reduced to 40%. "This was the right thing to do" from a license perspective despite possible ramifications. The Ops Director appeared to be under considerable pressure from "those above" and it was not clear if he personally agreed with the direction he had been directed to give the Control Room.

P-37

This Operations Superintendent said his concern is that *"People are so tired of speaking up about safety issues and not seeing results that they won't anymore." 9/3/03*

4. Since this incident, the Operations Manager has resigned, not feeling supported by senior leadership at PSEG Nuclear in this matter and others.

5. In April of 2003, there were grassing issues at Salem. There was a special meeting of the 12-hour shift to determine how to put three techniclans at Circ Water around the clock. One of the managers was infuriated and spoke up saying, Didn't we learn from nine years ago? We said we weren't going to do Herculean efforts to keep the plant on-line when river conditions are bad and not supporting safe operations. He asked, "Why are we doing this?" The response: "It doesn't matter. We're doing it."

In relating this incident to me, the manager expressed his frustration at not being able to get others to see that this was not the right thing to do and inconsistent with how we said we would operate. He felt unheard. He was afraid to escalate the issue "up the chain." He recalled being embarrassed when he went to the INPO Senior Plant Manager Course in 1994 and someone said to him, "You're from the plant where they do anything to keep the plant on-line." He realized, here again, nine years later, things hadn't changed.

6. Also since [redacted] left, and [redacted] took over, there was an off-gas issue at Hope Creek, looking for in-leakage. There were radiological safety concerns expressed. (Lower power, lower dose but less flow making leakage more difficult to detect). How this was handled (which I do not have details of) caused more concerns to be generated about our inattention to employee-voiced safety issues.

7. On March 27, 2003, the day before I left PSEG Nuclear, [redacted] confided in me saying many things including the following:

"I'm dong the best stakeholder management I can at this point to avoid an AIT from swooping in from the outside world."

A bit later in the conversation I said to him, *"I guess I'm naïve because I was really hopeful that we could put the real issues on the table and really deal with them. And..."*

[redacted] *"The real issues are with those in charge. The real issue is whose in charge. Is Enterprise in charge? Is the site in charge? Is the Union in charge? It's clear both of those parties don't want Nuclear in*

charge. That much is clear. And [redacted] has been in charge. And we can debate whether he did good or not. But the facts are I think he's kept non-Nuclear people from running the place into the ground. And the change that's occurring now is Fossil's [redacted] is running the place. You know, it's just the numbers. Well, I'll say it. That's what it looks like. That's what's occurring at this point. That's the direction it looks like it is going to go. They want that.

Harvin: *You know the Ops guys see that. That's what really scares them...that when you have non-nuclear people putting pressure on nuclear people to make decisions and the non-nuclear people don't understand all the aspects involved and what they are asking for or pressuring for....That was what the whole issue at Hope Creek was about...do we go back up before we find out why the valve...you know all that...that's what they told me. It's like: 'Who is running the show?' And thank God you didn't succumb to the pressure. They were afraid you would. If anybody weaker was in your job, what do you think would have happened?*

[redacted] *Uh....I don't know. What I do know is that I took a beating from [redacted] for spending $25 million in lost revenue on the profit and loss statement for Hope Creek.*

A bit later.....Why is that? [Skepticism in the leadership].

Harvin: *They knew the pressure you were under.*

[redacted] *Yeah, it is only going to get harder. Why? Because there's less money the company has these days. Gas prices are out the roof, there ain't no business coming from Global, and you can run a highly expensive gas unit but all you do is break even. So who's making your money? Well, this place....They want 95% capacity factor. 95% capacity factor gives you no margin. Zero. Absolutely none. That really is flawless execution. How do you get flawless execution with the goddamn attitudes here? Fucking A, (inaudible) place. It's not going to happen.....You're right. I carry an officer title. It doesn't mean shit. It doesn't mean shit.*

Harvin: *Who has all the power?* [redacted]

[redacted] *Absolutely. Absolutely. And as soon as the announcement was made that Harry was leaving, the power changed. That day. That day. We are now under a completely different process.*

Harvin: *He doesn't have a nuclear background, right?*

[redacted] *Nope....I don't know. It may be these are the things one should expect, given the new environment we are in. A deregulated company that runs a nuclear plant.*

Harvin: *The Salem guys told me they thought this would be our demise.*

[redacted] *Well, the NRC position from the word go, you know, Chairman Jackson, said that a few years ago about deregulation. Deregulation was going to be the watering down slowly and we'd see a safety culture change in nuclear power that would ultimately end nuclear power. The very thing it was intended to do to make it a viable entity ends up causing people to make poor decisions because of the economics. And it ends up being economically not viable anymore.*

8. The final part of this fax is an article I hope I never see. Many issues that have plagued NASA and led to the shuttle tragedy are at play at PSEG Nuclear. Our job is to avert another tragedy.

Thank you...sincerely.

Directed Hold Cont

JANUARY
Flawless Execution

→ Corrective Action Prgm — Inattentive
→ Knowledge + Skills Deficit
work force
→ Barriers Procedural Wk mgmt

Plant	Events	Issues
S/HC	• Winterization – Cold Weather Preparations (Lucky Lindi Lou 3 wks)	Mgmt Standards → mgmt Enforcing Standards
HC	• Hope Creek/Salem Downpowers	Ops Procedrues
S	• Circ Water System Maintenance	Maint Oversight & Procedures
S	• RHR Ht Exchanger Bolt Replacements	Engg Sandards
HC	• A/B Control Room Chillers	Ops/Engg Training
S	• 26 SW Pump – Red PRA Window	Ops Standards
S	• CO_2 Tank Fill	Ops Procedures
S	• 22 MG Set	Maint Oversight
S	• Rad Monitor DCP Configuration	Ops Configuration Management
S	• Hydrazine Spill/Over Fill	Ops Procedures
HC	• B Diesel Generator Exhaust Leak	Maint Standards
HC	• Control Room Duct Door LCO 3.0.3	Ops Configuration
S	• B Vital Bus Loss	Ops Configuration
	• 1 Slip OSHA Recordable	

① This Friday —

What is mgmt going to do Different?
Behaviors
Need mgmt review of Schedule —

FEBRUARY
Flawless Execution

Plant	Events	Issues
S	• 11 Stator Wtr Cooling Pump	Maint Work Practices
HC	• FRVS Recirc/Vent Fans	Tech Troubleshooting
HC	• B & D Diesels Out at Same Time	Ops Configuration
HC	• B Diesel Safety/Configuration	Maint Standards
HC	• A Diesel LCO Restoration	Maint Work Practices
S	• Service Air Loss/Protection	Ops Configuration/Pre-Planning
HC	• Tagging Breakthrough	Procedures
S	• 1 A Diesel 11SW39 Operability	Ops Configuration/Mgmt Standards
S	• Unit 1 Sulfate Levels 1.09	Procedures/Work Practices
HC	• Crossflow Indication Loss	Work Practices/Stnd
HC	• Compressor 10K 107 Leaks	Maint Practices
	• Missed Tech Spec Surveillances	Procedures
S/HC	• 2 OSHA Recordable Injuries	Standards

THINKING/THEMES

1. What has been really killed dead since 1/1/03? Little has been solved – Why?

2. What or How is the Corrective Action Program causing the direction to change? February is no better than January so I would say it isn't.

3. All of the events look preventable.
   All suggest pre-planning of work and the Depth and Breadth by you is missing

4. This Management doesn't recognize the seriousness of plant operations impacts.
   There must be an educational gap with you.

5. Management/Workers are falling short in fundamentals of their jobs
   - Basic electrical print reading for operators
   - Gaskets, seals, and joints for Maintenance
   - Use of procedures, practices, processes for Defense in Depth
   - Rinsing and water sampling
   - Technical problem solving
     - Temperature to seal life
     - Technical issues process and troubleshooting Control Loops

6. We don't know how to authorize work for success

7. We don't know how to practice or apply safety to our work.

This article is a "rewrite" of the article "Shuttle Report Blames NASA Culture" that was published on the 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" lead 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

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:

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