From: Glenn Meyer
To: A. Randolph Blough; Brian Holian; Daniel Holody; David Vito; Deborah Neff; Ernest Wilson; Hubert J. Miller; Jeffrey Teator; Richard Crlenjak; Scott Barber; Wayne Lanning
Date: 10/2/03 1:54PM
Subject: Salem Ad Hoc AllegationPanel - **2:30 pm**

We'll discuss the Salem allegations at 2:30 pm in allegation office. The attached writeup addresses the issues.

Salem / Hope Creek Allegation Approach

1. **Overall - Are Salem and Hope Creek unsafe to operate?**

   Based on current NRC understanding and activities, while regulatory concerns exist, there is no evidence that Salem and Hope Creek should be shut down for being unsafe.

   A. NRC has been monitoring Salem and Hope Creek closely. There have been many issues identified in Salem and Hope Creek inspections and assessments; these issues indicate a need for improvement at the facility, but also indicate that the plants still have substantial safety margins. Salem Unit 1 is in Regulatory Response Column of the Action Matrix; Unit 2 and Hope Creek in the Licensee Response Column. Beginning in February 2003 and also in July 2003 ROP assessment meetings, NRC determined Salem and Hope Creek had substantive cross-cutting issues for PI&R.

   B. The NRC has four full time inspectors assigned to the site, two at Salem and two at Hope Creek. There has been a high level of inspections, including three special inspections over the last 12 months. Through the first 8 months of 2003, Salem has accumulated over 5200 hours of regional inspection and assessment, more than any other Region I site, and the combined Salem/HC total is over 8100 hours. (The average in Region I for dual unit sites is about 3900.)

   C. NRC Regional Senior Management has made three detailed site visits over the last 10 months to monitor the facility and interact with PSEG managers and staff, including the new CNO, Roy Anderson.

   D. NRC has closely evaluated PSEG actions during recent events, including readiness for a plant restart after shutdowns. Some issues have been identified, but PSEG follow-up has been acceptable overall. Although the allegations show considerable internal PSEG discussions existed, the appropriate actions appear to have been taken.

   E. Several key managers (CNO, site VP, Hope Creek plant manager, and Salem Ops Manager) are new to the site since March 2003.

2. **Management Attitudes - Is production favored over safety by senior managers?**

   Concerns

   - March 17, 2003 at Hope Creek [redacted] confide that [redacted] pressured for restart without forced outage - bypass valve incident; Forced outage & bypass valve repair occurred.

- June 17, 2003 at Hope Creek - EDG leakage exceeds LCO time; pressure to avoid shutdown; [redacted] directed operato[redacted] o not shutdown; shutdown commenced within acceptable time frame and met regulations.

- Sept 24, 2002 at Salem [redacted] ECP confidential report substantiates allegation; Third Step Grievance.

- Fall (?) 2002 at Salem - Manager [redacted] directed [redacted] to NA a startup checklist step. [redacted] tried to have [redacted] fired but was unsuccessful.

- Salem grassing approach (i.e., heroic efforts) deviated from expected approach / lessons learned from 1994 grassing [redacted]

- 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 [redacted]

Alleger-provided listing of 29 people aware of problems to varying degrees and possibly willing to corroborate issues and concerns.

Sound bites from taped discussions with senior managers

Approach

1. Interview managers who have left site [redacted]

2. Interview some managers who the alleger believes can provide additional insights - alleger's list of 29 names.

3. **SCWE - Is the PSEG staff able to raise safety issues?**

- March 17, 2003 at Hope Creek [redacted] told alleger he did not have the authority to stop the evolution (reactivity excursion during the bypass valve shutdown?) even though he knew it was ill-conceived.

- Excessive use of temporary logs to monitor degraded equipment (NEOs can provide)

- Comments (mostly negative) from ECP survery - 4Q 2002 & 1Q 2003

Approach -

1. Interviews with all shift managers at Salem and Hope Creek by technical/OI/consultant team to generally address SCWE and develop any other issues.

2. NRC-directed survey of operations staffs to address specific issues raised

or should have been raised in an anonymous manner to NRC ?

3. Get April 2003 results of Gallup G-12 survey (multi-year effort to measure staff engagement, an indirect measure of SCWE) and multi-year results of ECP surveys.

4. Technical Review of Specific Incidents

- Technical review of above specific incidents (many previously reviewed) to assure technical / nuclear safety considerations were met in light of new info; NA of startup checklist step (Fall 2002?) needs to be followed up.

Approach - Residents perform review and document in memo to file.

5. Discrimination

- Termination following raising safety concerns to [redacted]
- Termination date of April 16 moved up to March 28 at [redacted] request
- ECP report of July 17 and Winston-Strawn review find her alleged discrimination to be unsubstantiated due to Human Resources' decisions to end position and to advance termination date.

Approach - OI has opened a discrimination case, including interviews and review of Winston-Strawn investigation report.

6. Wrongdoing

- Alleger states that PSEG destroys unfavorable documents
- Salem incident in which [redacted] directed [redacted] to NA a startup checklist step
- Three specifics [redacted] knows some [redacted] was asked to rewrite a notification, Winston-Strawn investigation statements differed from interviewees' accounts

Approach - Perform additional review to clarify general statements for possible OI review; obtain specifics of startup checklist step issue.

October 2, 2003

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