

From: James Wiggins
 To: Scott Barber
 Date: Thu, Oct 9, 2003 8:07 AM
 Subject: Re: Highlights of [REDACTED] Interview (10/6) on Salem SCWE

Good report, Scott.....really demonstrates the value of pairing an experienced, knowledgeable tech staffer with our OI investigators. I'm sure, w/o your help, Eileen would have been drowned by tech detail....

I presume that the tech issues involved were either already known by us and factored into our routine inspections/observations when the problems occurred.....otherwise, we may have to feed items from the interview fwd, as appropriate.

>>> Scott Barber 10/08/03 11:24AM >>>
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Eileen Neff and I interviewed [REDACTED] for approximately 2 ½ hours on October 6. The interview began about 5:30 p.m. at his house. Listed below are some highlights of the interview.

- Regarding the "N/A'ed step of the startup procedure" - we discovered that this issue involved [REDACTED] directing an SRO to N/A a step regarding the need for a containment walkdown by the [REDACTED] prior to startup from a Salem Unit 2 scram from problems in the 500 KV switchyard in mid-2002. This was a redundant step to the normal SRO walkdown that is done after every outage. According to [REDACTED] this step was added as a lesson learned from the Davis Besse event to ensure that the highest level of management on-site was fully aware of the containment conditions prior to closeout. Apparently [REDACTED] believed that the walkdown done separately by an SRO was sufficient to meet the intent of this procedure step and directed that it be N/A'ed. [REDACTED] corrected him and told him that both [REDACTED] were going to do the walkdown which they both did. [REDACTED] indicated they identified some minor boron leaks that had to be corrected prior to restart. This resulted in a one day delay in their restart schedule. This concern was unsubstantiated.

- Regarding the March 2003 Hope Creek event involving a degraded turbine bypass valve - [REDACTED] portrayed a very different picture than what was in the allegation. He indicated that Hope Creek had planned a short duration outage to correct three technical issues (leaky EDG exhaust piping, recirc pump seals, and an RHR valve problem). He stated that the outage went well with all of the previously identified issues being successfully addressed. During startup on March 14, 2003 after main generator synchronization, he was called by [REDACTED] who informed him that No. 2 turbine bypass valve (TBV) failed to fully close and that operators had halted power ascension to assess the problem. He indicated that [REDACTED] provided a course of action of how to safely proceed with shutdown which is what was implemented on March 16. [REDACTED] stated that he told [REDACTED] to proceed with course of action he described on how to safely shutdown the plant. [This description was derived from IR 50-354/2003-003 - After midnight on March 17, while controlling the TBVs on the bypass jack a perturbation caused the No.1 and 3 BPVs to pulse full shut and back open to their original position which caused a minor change in reactor power, pressure, and level. After a quick review by engineering, the depressurization continued and a more significant transient occurred in which the No. 3 BPV cycled from 0 percent to 75 percent open which caused a reactor level decrease of 8 inches and a 7% increase in reactor power. Operators stopped using the BPV jack to lower pressure and used pressure set as the pressure control means for the remainder of the shutdown and cooldown sequence. Operators completed the shutdown and cooldown with no further operational challenges. Subsequent BPV jack troubleshooting identified a problem with the BPV jack potentiometer which contributed to the erratic response of the BPV jack. PSEG management initiated corrective action after the second power transient, including prohibiting the use of the BPV jack when the reactor is critical, conducting a self assessment, and initiating an independent review of the transient, including upgrading the initial notification to a significance level 1.] After the plant was shutdown, the repair activities took approximately six days to complete. In a later discussion, [REDACTED] indicated that [REDACTED] was disappointed that extension of the original shutdown took

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six days instead of a more reasonable three day time frame to complete and this additional time (extra 3 days) cost the company 25 million dollars. [REDACTED] main comment on this after the fact discussion was that this was the only negative feedback that he received on the issue, and he took it as a learning experience on how to better manage emergent problems. He indicated that this interaction and others did not cause him to feel that he could not raise safety concerns to senior corporate management.

- Regarding the June 2003 EDG intercooler leak [REDACTED] had an interesting view on this issue. He indicated that he thought the organization let him down because of the slowness in the way the operability decision was made. He erroneously believed that the final operability call at the eleventh hour was made when engineering finally concluded that they met the design basis as written. He also indicated that this timeliness problem was exacerbated by some organizations that were involved because they should not have had a part in the decision making. He attributed the organizational delays to the matrixed organizations that were in place at PSEG during [REDACTED] tenure. He also indicated that this type of organization diluted accountability which INPO mentioned as a contributor to their third "3" grade in as many years. In reviewing the circumstances at the time, we noted that [REDACTED] understanding of the cause of the slowness in making the operability decision was in error since engineering had, in fact, revised the design basis to change the time to take action for a leak from the jacket water system from 7 days to 1 day (24 hours). The time frame (24 hours) to not credit operator action was consistent with the assumptions in the accident analysis. That revision to the design basis was HC's basis for exiting the LCO, and it was not a lack of understanding of the original design basis. It was interesting that [REDACTED] did not fully understand this distinction.

These are some initial highlights that are generally representative of some aspects our interview with [REDACTED]. To get a full understanding, it would be appropriate to read the full transcript once it is made available.

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