Salem & Hope Creek Update Agenda November 14, 2003 - Won-conservative deux - product or over sefet - Union presene Agenda Package Contents: 1) Update Agenda 2) Attachment A (Interview/Assessment Status Table) 3) Attachment B (Regulatory Action Schedule) 4) Attachment C (Background/Chronology) 5) Attachment D (External Q&As) ANY EVIDENCE OF UNSAFE OPERATION? NO 1. Operating review of Salem & Hope Creek - No recent reports to NRC or events 2. Allegations Status - Review interview progress & results (Attachment A) **Upcoming Regulatory Operations** 3. Review schedule (Attachment B) Follow-up Items 4. a) Explore conduct of operations aspects of issue #4 operating the Feedwater valve). b) Revise Att. A format to include a column indicating whether the issue listed is a technical violation or wrongdoing (50.5 Deliberate Misconduct ... willful or careless disregard ...) as well as a brief statement of 10 status add - I/L- MOULTONS DUVENING c) Keep External Q&A's up-to-date ... ready for distribution if/when the issues go public d) star 1 aut Con ...ormation in this record was deleted - Assess what we have so for Act, exemptions 70 - From SM intervents in by 12/15/23 014 G:\BRANCH3\Allegation SCWE\Salem-HC-UpdateAgenda.wpd man

### NRC ASSESSMENT OF SIGNIFICANT SALEM/HC ALLEGATION

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	Discreet Issue / Event (Derived directly from 2003-0110)	NRC Assessment (Including interview results)	Technical Violation?	Wrong- doina?	
1	March 17, 2003 at Hope Creek -	Interviews to date have suggested that the concern here was between the stand his department heads. He apparently "harassed" (From interviews with them for four hours on why a shutdown to repair a TBV was necessary when all of the department heads believe the decision to shutdown was a "no brainer". Although non-conservative decision making is a possible root cause, there was no TS violation.	No	N/A	all
2	March 17, 2003 at Hope Creek - 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.	Not yet developed - More to follow	No	N/A	
3	June 17, 2003 at Hope Creek - EDG leakage exceeds LCO time; pressure to avoid shutdown; the directed operator interaction to shutdown; shutdown commenced within acceptable time frame and met regulations.	Interviews to date have suggested that 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.	No	N/A_	
4	Sept 24, 2002 at Salem	Interviews to date have suggested that this industrial safety issue may have been substantiated. Many NEOs noted that the <b>constant</b> went and the field and <b>constant</b> without: an NEO to operate the valve, wearing the necessary personal safety gear, and without following the work control process. Although this issue may have been substantiated and non-conservative decision making was a possible root cause, this is not a an NRC regulated issue.	No	N/A	
5	Fall (?) 2002 at Salem - Manager Fall (?) 2002 at Salem - Manager for NA a startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. Fall (?) 2002 at Salem - Manager for the startup checklist step. f	New information received on November 6, indicates this alleged activity may have actually occurred when a single value indicates this alleged activity may have actually occurred when a single value indicated dual indication during this routine stroking evolution. A survey 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 the step 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 alleger's assertion.	No	N/A	

Predecisional Information - Not for Release to the Public

	Discreet Issue / Event (Derived directly from 2003-0110)	NRC Assessment (including interview results)	Technical Violation?	Wrong- doina?
6	Salem grassing approach (i.e., heroic efforts) deviated from expected approach (lessons learned from 1994 grassing West find even trally op efflu alley caught hun before	supported any efforts to station additional operators in the intake to clean the screens during heavy grassing periods. His approach would have been to take the unit offline. H indicated that he may have told the alleger that he was concerned that some of the outage staff would have chose to augment screen cleaning with operators vice shutting down the unit.	No e e	N/A
7	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"	was being developed but he interview that he was not in a role in RP at the time this issue was being developed but he did recall having conversations with PSEG communications people on how to handle the issue. He said he may have discussed this with the alleger. The NRC has a great deal of information on this issue that has been derived from inspection activities including numerous face-to-face interactions between inspectors and PSEG managers and staff.	None from this allegation	N/A
	Excessive use of temporary logs	Not yet developed - More to follow	TBD	TBD
	Salem 2 ISI relief request re: piping UT (coverup?)	Not yet developed - More to follow	тво	TBD
	HC offgas issue after the second took over. Rad safety concerns expressed but not resolved	indicated some knowledge of this issue since he believe it pertained to elevated believe it pertained to elevated believe it of excessive air in-leakage into the condenser. He indicated that interpretent wrote a somewhat inflammatory notification because the NEOs had to try to identify the location of the leak in higher than normal radiation fields. The location of the leak eventually was discovered and the offgas leakage reverted to its pre-in-leakage levels.	IC No ify	N/A
	HC employee allegedly asked to modify a Notification re: "inteakage" Officer - Woher Hory Wohel NID - Wided	Source indicated some knowledge of this issue since he believe it pertained to elevated he offgas flow rates due to excessive air in-leakage into the condenser. He indicated that Souber wrote a somewhat inflammatory notification because the NEOs had to try to iden the location of the leak in higher than normal radiation fields. The location of the leak eventually was discovered and the offgas leakage reverted to its pre-in-leakage levels.	IC No ify	N/A
	- were to getting dose during visits to find the leek.			······

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	Discreet Issue / Event (Derived from interviews)	NRC Assessment (including interview results)	Technical Violation?	Wrong- doing?
1	PSEG decision making relative to #14 Steam Generator (SG) Feed Regulating Valve (FRV) believed to be stuck at 74% open	Interviews to date have suggested that 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.		
2	In the Spring 2001 outage, a Salem Unit 1 reactor trip was caused by a main generator current transformer failure. The second se	Not yet developed - More to follow		

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Predecisional Information - Not for Release to the Public

Attachment A

# Salem & Hope Creek Schedule

Week of:	Activities	When	
Nov. 3 <sup>rd</sup>	Larry Scholl Special Inspection Onsite/Debrief	All week	
	Status/Update Briefing	Nov. 7 <sup>th</sup>	10:00am
Nov. 10 <sup>th</sup>	Inspection Reports Issued	Nov. 11 <sup>th</sup>	
Nov. 17 <sup>th</sup>	Status/Update Briefing	Nov. 17 <sup>th</sup>	9:30am
	3rd Quarter Assessment Meeting	Nov. 17 <sup>th</sup>	1:30pm
Nov. 24 <sup>th</sup>	Hope Creek Operator Licensing Meeting	Nov. 24 <sup>th</sup>	9:30am
	Supplemental Inspection Exit ?		
	Special Inspection Exit ?		
Dec. 1 <sup>st</sup>	Status/Update Briefing	Dec. 1 <sup>st</sup>	1:30pm
Dec. 8 <sup>th</sup>	Site Visit (9 <sup>th</sup> & 10 <sup>th</sup> ? 1 day ?)		

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### Salem/Hope Creek Allegation Background/Chronology

Issue/Event Date	Description
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 the second provide the second
Not Specified	Hope Creek employee allegedly asked to modify a Notification re: "in-leakage"
Spring 2001	In the Spring 2001 outage, a Salem Unit 1 reactor trip was caused by a main generator current transformer failure. The second started up by a particular date or their NRC performance indicator was going to "go white." allegedly harassed operations daily by asking day "when are you going to start the plant". Operations then told start up would start up when they thought they were within a day of putting steam into the main turbine. Although second to do so because it was contrary to their safety analysis.
Spring 2002	Salem grassing approach (i.e., heroic efforts) deviated from expected approach/lessons learned from 1994 grassing a second second processing. 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.
Sept. 24 <sup>th</sup> , 2002	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), <b>Here a</b> State (20' to 40' plume from the bonnet of agreed with the shift operators that the plant should be shut down to affect repairs. If to speak with "upper management " and, upon his return, subsequently the which isolated the steam leak avoiding a shut down. Confidential report substantiates allegation, Third Step Grievance ( <b>Confidential be perated the valve</b> without regard to his own personal safety, without a Nuclear Equipment Operator (NEO), and without the permission/knowledge of control room personnel).
Fali 2002	Manager <b>General Provide Andrew Prov</b>
Nov. 2002	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" (

# Salem/Hope Creek Allegation Background/Chronology

Issue/Event Date	Description
March 17 <sup>th</sup> , 2003	<ol> <li>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).</li> <li>Entering a planned shutdown to repair 3 technical/mechanical failures (late Sunday / early Monday morning).</li> <li>Monday morning (0800) Turbine Bypass Valve (TBV) stuck open (47%). TBV closed fully during subsequent testing.</li> <li>The concern here was between the about whether or not a shut down was required. The concern here was between the additional his department heads. He apparently "harassed" (from interviews with the second structure 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>Heated discussions about the duration of the forced outage.</li> </ol>
June 17 <sup>₽</sup> , 2003	Hope Creek - EDG leakage exceeds LCO time; pressure to avoid shutdown; directed operator difference ito 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.
Sept. 3' <sup>d</sup> &4 <sup>th</sup> , 2003	Initial allegation contact between RI-2003-A-0110 alleger & Dave Vito.
Sept. 5 <sup>th</sup> , 2003	Alleger informed of right to file a discrimination complaint with the Dept. of Labor (DOL).
Sept. 9th, 2003	Initial recorded interview with alleger & 1 <sup>st</sup> Allegation Review Board (ARB).
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. 25 <sup>th</sup> , 2003	Interviews conducted Sept. 25 <sup>th</sup> through Oct. 9 <sup>th</sup>
Sept. 29 <sup>th</sup> , 2003	Alleger filed civil discrimination law suit against PSEG in Morris County, N.J.
Sept. 30 <sup>th</sup> , 2003	Alleger sends a letter, via email, to the NRC, Region I, Regional Administrator indicating that the the second sec
Oct. 2 <sup>nd</sup> , 2003	2 <sup>nd</sup> ARB
Oct. 9 <sup>th</sup> , 2003	More email received from alleger.
Oct. 11 <sup>th</sup> , 2003	More email received from alleger.
Oct. 14 <sup>th</sup> , 2003	Interviews conducted Oct. 14th through Oct. 21st

#### Salem/Hope Creek Allegation Background/Chronology



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