September 28, 1988

### UNITED STATES OF AMERICA NUCLEAR REGULATORY COMMISSION

#### before the

# ATOMIC SAFETY AND LICENSING BOARD

In the Matter of

B810050123 B80928 PDR ADDCK 05000AA3

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PUBLIC SERVICE COMPANY OF NEW HAMPSHIRE, et al.

(Seabrook Station, Units 1 and 2) Docket Nos. 50-443-0L-1 50-444-0L-1

(Onsite Emergency Planning and Safety Issues)

## AFFIDAVIT OF GARY J. KLINE

I, Gary J. Kline, being on oath, depose and say as follows:

 I am the Technical Support Group Manager for New Kampshire Yankee. As the Technical Support Manager, my responsibilities include managing the Systems Support Department, Reactor Engineering Department and a Program Support Department. During the Seabrook Station Graded Exercise in June, 1988, I was the first shift Technical Services Coordinator in the Technical Support Center (TSC). As the Technical Services Coordinator my responsibilitie. included directing various engineering activities and Operation Support Center (OSC) coordination as well as any other functions delegated by the Site Emergency Director during the conduct of the exercise. I am also familier with the Seabrook Station plant design, operating modes, emergency operating procedures and the arrangement of the plant systems/components involved in the exercise. In addition, I have acquired a Senior Reactor Operator's license at two commercial nuclear power plants (one at Seabrook Station), both PWRs, as well as obtaining Shift Technical Advisor certification at Seabrook Station. A statement of my professional qualifications are attached hereto and marked "A".

2. The NRC in Inspection Report No. 88-09 stated that:

"<u>Results</u>: No violations were identified. Emergency response actions were adequate to provide protective measures for the health and safety of the public."

3. The above reference inspection report identified both strengths and weaknesses. One of the weaknesses identified in this inspection report is the factual basis upon which the Massachusetts Attorney General (MA AG) relied in filing its motion. The purpose of this affidavit is to address the affidavit of Robert D. Pollard and the following excerpt from the NRC Inspection Report relied upon by the MA AG.

> "The Technical Support Center (TSC) and the Emergency Operations Facility (EOF) staff displayed questionable engineering judgment and/or did not recognize or

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address technical concerns (50-441/88-08-01). For example:

"- Efforts continued to restore the Emergency Feedwater Pump after a large break LOCA; and

"- A lack of effort to locate and isolate the release path."

4. As discussed in the following paragraphs the continuing efforts to restore the Emergency Feedwater Pump (EFW) after a large break LOCA did not affect nor would it have affected the response by the TSC to other higher priority activities involving the LOCA. Further these restoration/repair activities were continued to demonstrate the technical assessment ability of TSC team members.

5. Subsequent to the declaration of the Alert and during the cooldown, the second Emergency Feedwater (EFW) pump became inoperable which resulted in the declaration of a Site Area Emergency. At that time the TSC recommended an immediate shutdown and cooldown of the plant. This recommendation was denied by an Exercise Controller and shortly thereafter the power reduction was also stopped by an Exercise Controller. One of the guidelines I was given was that the directions of the Controller will be followed without question. This necessarily includes directions which are contrary to the recommendations and judgment of the exercise participants. This is done to permit the exercise

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to continue so that the objectives of the exercise can be attained.

6. Since one of the two EFW pumps and the starting Feedwater pump were unavailable, efforts were initiated to repair and restore the inoperable EFW pump.

7. Subsequent to the declaration of the Site Area Emergency, a LOCA occurred. As a result, the activities of the TSC were reprioritized to respond to activities directly involving the LOCA.

8. Discussions took p'a 2 between key personnel in the TSC as to whether to continue the repair efforts on the EFW pump. Although it was recognized that the EFW system may not be needed to mitigate the consequences of a large LOCA, it was decided that these efforts should be continued for a number of reasons. These reasons included: that these efforts would not affect other ongoing LOCA response activities, and that these actions should continue to assure a backup heat removal method if a need for future use arose, even if a current need was not perceived. It should be recognized that i' is the responsibility of the TSC to assure that equipment will be available to the extent that these activities do not interfere with accident mitigation functions. It was also believed that these restoration/repair efforts should be continued to further demonstrate the TSC's technical assessment capability.

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9. There were frequent discussions between key TSC personnel to assure that the EFW pump restoration/repair efforts were not interfering with other ongoing higher priority activities. It is clear to me that these repair activities would have been terminated, if it appeared that these actions could affect accident mitigating capabilities or actions to restore failed accident mitigating capabilities, such as the Containment Building Spray (CBS) pump repair/restoration efforts.

10. As noted in the Affidavit of Gregg F. Sessler at ¶ 13, the step in the emergency procedure that is also a subject of the Pollard Affidavit involves the controlled depressurization of the steam generators -- a factor which is given some importance in the Pollard Affidavit. However, what that affidavit does not seem to reconcile is how one can justify the depressurization of the steam generator as being necessary yet also argue that efforts to restore a backup for the system necessary to assure a controlled depressurization is not needed.

11. As discussed in the following paragraphs there was a concerted effort to locate and isolate the release path.

12. A concerted and planned effort was made to locate and isolate the source of the containment bypass leakage (i.e., the release path). The source of the leak was initially isolated to the containment enclosure ventilation

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area which included the electrical penetration area, the enclosure building annulus, the enclosure area ventilation room, the mechanical penetration area, the equipment vaults and the charging pump cubicles.

13. Efforts were continued to further localize the leak to one of the areas within the enclosure ventilation area. These efforts included reviewing of installed radiation monitoring instrumentation data and sampling sumps for indications of radioactivity, reviewing sump indications/ alarms for signs of leakage and dispatching survey teams to areas which could be accessible following a LOCA. It should be noted that it is well known to the emergency response staff that certain of these areas would not have been accessible for direct inspection or for any actions to isolate any leak. This is because of the radiation levels associated with the large LOCA. A survey team did encounter high radiation levels outside a door to the electrical penetration area and was recalled prior to entry for personnel safety.

14. As a result of these efforts it was determined that entry into these areas would be required to localize the 'eak. After reviewing the radiation level data for these areas, a decision was made to postpone entry into these areas until the radiation levels were reduced to acceptable levels.

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15. Based on the foregoing paragraphs I have concluded that:

- the efforts to restore the Emergency Feedwater (EFW) Pump after a large break LOCA did not affect the TSC's response to activities associated with LOCA ;

- the TSC staff recognized that it was unlikely that the EFW pump would have been required; however, it was decided to constitute restoration efforts to further demonstrate the TSC's technical assessment capability;

- there were considerable efforts made to identify the release path:

- entry into areas for a direct inspection and ultimately isolating or repairing the leak was postponed until radiation levels were reduced.

16. Therefore, the actions by the emergency responders were deliberate and well reasoned. At no time did any of the emergency responders not recognize or misunderstand the plant conditions and the actions that should be taken.

Gary J. KVine

### STATE OF NEW HAMPSHIRE

Rockingham, ss.

September 28, 1988

Then appeared before me the above subscribed Gary J. Kline, and made oath that he was the author of the foregoing affidavit and that the statements set forth therein are true to the list of his knowledge.

Before me,

Notary Public Succession Expires: 3/29/1992

#### GARY J. KLINE

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Bachelor of Science in Nuclear Engineering, Lowell Technological Institute - 1972

Shift Technical Advisor Certification, including 60 credit hours from Memphis State University - 1982

of the Plant Operation Review Committee.

LICENSES

Senior Reactor Operator License Millstone, Unit II - 1977

Senior Reactor Operator License Seabrook, Unit I - 1985

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1973 to 1974	Maine Yankee <u>Reactor and Computer Engineering</u> <u>Department</u>
	Participated in physics testing, core analysis, plant performance, refueling operations.
1974 to 1976	Millstone, Unit II Reactor Engineering Department
	Participated in initial core load and startup of Millstone Unit II. Functions included physics testing, fuel receipt and inspection, core analysis, primary and secondary plant performance.
1976 to 1978	Millstone Unit II Reactor Engineering Department Supervisor
	Responsible for Unit II Reactor Engineering Department functions. Directed first refueling core reload operations and startup testing. Member

1979 to 1986	Seabrook Station Reactor Engineering Department Supervisor
	Responsible for staffing and developing Reactor Engineering Department functions; reviewing operating procedures; fuel receipt and inspection, and reactor engineering related startup test procedure development. Member of the Station Operation Review Committee. Primary responder to the Reactor Engineering position in the Technical Support Center.
1986 to 1987	Seabrook Station Technical Support Manager
1907	Responsible for the Reactor Engineering Department and a plant performance engineering department. Responsible for initial core load. Primary responder to the Technical Services Coordinator position in the TSC.
1987	Seabrook Station System Support Department Manager
	Responsible for the formation and implementation of an engineering group based on the system engineer concept. Responsible for design change implementation; corrective maintenance; plant performance monitoring; and technical support to the Station staff in mechanical, electrical, and instrumentation and control disciplines. Member of Station Operation Review Committee. Primary responder to the Technical Services Coordinator position in the TSC.
1987 to 1988	Seabrook Station Technical Support Group Manager
	Responsible for the System Support Deportment, Reactor Engineering Department and the Program Support Department. Member of the Station Operation Review Committee, Radiation Safety Committee and primary responder to the Technical Services Coordinator position in the TSC.

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