To: Executive Board

The purpose of this letter is to apprise you of ongoing challenges in the Energy Northwest culture and plant performance. These challenges continue even after the Pillsbury investigation you conducted.

A. Safety Culture

Attached is an email related to a situation where operations management directed a manager ([REDACTED]) to provide direct oversight on an employee that had an active and unresolved Employee Concern against the very same manager that was set to provide oversight. Managements decisions placed nuclear safety in second place during a critical reactivity maneuver of the nuclear power plant. Of importance to note is that in a contemporaneous conversation from the [REDACTED] ([REDACTED]), to the [REDACTED] ([REDACTED]), [REDACTED] [REDACTED] stated the following: **"I didn't think [REDACTED] should come out to observe the crew in order to avoid potential conflict".** The [REDACTED] is responsible for protecting the public and employees in all matters related to nuclear safety. In this case the [REDACTED] opinion was overridden for some reason and placed the safety of the public in second place.

You should also gain a better understanding of the recent litigation that was settled in the matter of Cameron v EN. In this case, operations management humiliated an EN teammate in front of his peers. EN settled that case on the eve of trial – what was management afraid of after spending many thousands of public dollars preparing for trial?

B. Protection of the Public from Radiation

As you may know EN was recently earned NRC violations for improper shipping of radioactive material on public roads. The following are excerpts for the Root Cause Analysis – we will let them speak for themselves and you can judge your oversight responsibility on such important matters of public safety (emphasize added):

Significance of Event:

> *Columbia Generating Station (CGS) shipped radioactive waste in a container that is not designed for the classification of that waste.* ***This represents a reduced margin of safety to the public when the waste was being transported on public roadways*** *(approximately 3 miles). Additionally, CGS received violations on shipment 16-40 (liner 16-059-OT) from the WSDOH of Radiation Protection. Due to the nature of the violation found with the shipment, authorization to use the commercial low-level radioactive waste disposal site by Energy Northwest was suspended indefinitely. Further shipments will be refused until Columbia Generating Station's use permit is reinstated.*

Saving money was placed over public safety and compliance with the law:

__A decision was made to use a lower classification__ container than was used for the previous SFP shipments. The decision was initially prompted by a suggestion from the RXM Project Lead to look for __anything we could do differently to eliminate unnecessary cost and delays.__ The project had already exceeded the FY16 project budget and was delayed into FY17 for additional funding to complete it. Based upon the vendor characterization documentation, the RWTS determined that we could use a Type A container and thus consolidate all remaining waste items into one shipment versus two shipments. __It was estimated that up to $300k savings could be realized.__

Procedures not followed and the [redacted] did not heed the advice of [redacted] staff, we believe the [redacted] has been removed, but you must consider how high does this disengaged and unaware culture exist:

__A decision was made to ship the container without performing a survey__ of the liner itself without the cask. __PPM 11.2.23.1 states "The HP Technician (HPT) should perform and document a shipping survey..."__ but these surveys are performed outside the entire container, not the liner by itself. Per the RWTS, it is common station practice to perform a final survey on liners with low level rad waste before they are shipped off site. That final survey dose rate information is typically what is recorded on the shipping manifest. The RWTS chose not to do the final survey in this case because he was concerned that there would be too much exposure (dose) to personnel to conduct that survey. The manifest documents instead recorded the dose rate calculation from the characterization. This is an acceptable method for documentation but is a departure from our normal practice. __On the day of the shipment, one RP supervisor expressed his concern and challenged the RPM and RWTS__ about proceeding with this shipment. There were discussions involving the RWTS, the RPM, and the RP Manager about this container, and based on the characterization the decision was made to proceed with shipment. [CC1]

Organizational and Programmatic Causes:

Management Oversight – __Did not ensure adequate response to address continuing problems with rad waste shipping program__ (refer to internal OE summary); Unclear roles for groups involved with SFPCU project; Surveys were not revied (sic) by supervisor prior to sending to the vendor; Inadequate program oversight. [CC2]
Decision Making – Decisions not made at the appropriate level with complete understanding of the basis and risks; Decisions not thoroughly challenged and vetted. [CC1]

Past events and lessons not learned:

The above issues and __events indicate that a range of weaknesses related to rad waste shipping, handling, and documentation, have been identified over the past ~2 year period__. There have been __multiple apparent cause evaluations__ conducted on these prior issues, including one common cause evaluation. Causes identified include individual performance, failure to use EPTs, weak procedures, and errors in decision making.

Summary:

What does all this mean to you as a governing board member responsible for the oversight of nuclear power plant and the protection of the public from radiation?

1. There is agency culture of intimidation and retaliation at the highest levels of the company. To prove this, the [redacted]'s reasonable and simple recommendation to support a Safety Conscience Work Environment and ensure reactivity is managed was ignored.

2. The [redacted] and [redacted] are not being held to account for the culture that has precipitated poor performance and poor decision making related to matters of nuclear and radiation safety.

3. The [redacted] and [redacted] continue to be disengaged after the last investigation. While we can no longer see their calendars, they continue to be absent at a remarkable rate and on occasion absent at the same time. We know you think this issue in laughable, but as performance continues to degrade you must ask yourselves if they don't need to be here to improve performance why area they here at all? And with a very important outage coming in just a few weeks, shouldn't there be engaged oversight at all levels during the months preparing for the outage.

4. Since we started our letter writing:

    a. Columbia Generating Station is still in the bottom quartile of the all nuclear plants in the United States by measures of safety and reliability.

    b. The violations from the NRC related to the Radiation Waste Shipment will place us in the "second column" of NRC oversight, unless our appeal is granted. There are only 12 plants in the second column or worse, this is bottom quartile performance.

    c. Columbia Generating Station may be in the worst quartile by both INPO and NRC measures.

    d. These issues make it clear to us over the last 36 months under the disengaged leadership of the [redacted] and [redacted] we are not solving and stopping our poor performance since we seem to be repeating the same issues over and over again (radiation waste, industrial safety, operations safety culture, INPO index performance). If you believe the [redacted] and [redacted] are engaged than what value is their leadership providing?

From: [redacted]
Sent: Sunday, April 02, 2017 3:54 PM
To: Schuetz, Robert E.; Prewett, Randall A.; Jones, Joshua A.; Knudson, Gregory M.; Morrison, Sidney W.; Hugo, Bruce R.; Hammons Jr, Robert D.; Stephens, Danny J.
Subject: April 1st issue

On April 1st I brought up my concern at approximately 0600 that [redacted] was going to observe the downpower from 93% to 65%. I have an outstanding concern from January 24th with ECP concerning [redacted] using an evaluated scenario to retaliate against me. I am concerned [redacted] April 1st observation of me performing the downpower could be further harassment and intimidation.

I informed the [redacted] immediately of my issue due to the fact my concern from January has not been closed. In fact I had no follow up since January 24th.

I was in Manpower as a watch stander. [redacted] should have excused himself from observing me based on our open issue with Employee Concerns Program.

I informed the [redacted] I was not comfortable performing the downpower with [redacted] present. [redacted] presence would be a distraction to the reactivity event that would be occurring. My solution was that [redacted] be declined access to the Main Control room during the downpower. There was plenty of time to call and inform him. [redacted] was the only person at Energy Northwest I have an unresolved issue with. Any other member of Management could observe the evolution if desired.

Three hours after bring up my issue I was informed that a Reactor Operator was being called out to take my place. At that point I would be relieved to go downstairs. [redacted] was still going to perform an observation of the downpower. I expressed my disagreement with that decision to the [redacted]

Ultimately a Reactor Operator was not called out. Instead [redacted] came out to take the place of the fourth RO. This is significant as a fourth Reactor Operator is required by procedure when maneuvering the plant below 85% power. It is also important given the degraded condition of Columbia Generating Station. There would be a lot of alarms to respond to during the evolution. Only a Reactor Operator can respond to alarms.

At 1145 I informed the [redacted] that I felt like I was being attacked.

At 1149 I was relieved from watch as [redacted] and left the Main Control room. I consider this disrespectful and humiliating. Being relieved was retribution for bringing up my concern.

There are several issues with what unfolded:

1. [redacted] should not have been more important than having a fourth Reactor Operator in the Main Control room during the transient. This is validated by the feedback given to the crew for alarm response. A conservative bias was not applied when I was removed from the watch team as a well prepared member of the team with no replacement.

2. The [redacted] also observed the evolution. As a prior [redacted] and [redacted] at CGS he is very competent as an observer. The [redacted] [redacted] that was called out to be a peer checker was a competent observer also. There was no necessity for [redacted] to observe the evolution.

3. The roles of the Reactor Operators on watch were changed prior to the evolution. This created an error likely situation.

4. Nuclear Safety took second place on April 1st.

5. Intimidation of myself was allowed to continue. I find this the most disappointing.