July 11, 2001

EA 01-158

Mr. Robert M. Bellamy
Site Vice President
Entergy Nuclear Generation Company
Pilgrim Nuclear Power Station
600 Rocky Hill Road
Plymouth, Massachusetts 02360-5599

SUBJECT: NRC OFFICE OF INVESTIGATIONS REPORT 1-2000-002
(PILGRIM NUCLEAR POWER STATION)

Dear Mr. Bellamy:

This letter refers to an investigation initiated by the NRC's Office of Investigations (OI) on January 6, 2000, at the Pilgrim Nuclear Power Station (PNPS) to determine if a PNPS licensed reactor operator (RO) falsified readings while touring the reactor building on December 8, 1999. The OI investigation was initiated after you identified the misconduct, investigated the matter, terminated the employment of the RO and informed the NRC. Based on the evidence developed during its investigation, OI substantiated that the RO knowingly provided incomplete and inaccurate information on licensee records documenting the reactor building tour.

The NRC has determined that an apparent violation of NRC requirements occurred. The apparent violation involves the creation of a materially false record. 10 CFR 50.9(a) states that information required by the Commission's regulations to be maintained by a licensee shall be complete and accurate in all material respects. As noted in the enclosed OI Factual Summary, the evidence indicates that the RO provided incomplete and inaccurate records of a reactor building tour conducted on December 8, 1999. This caused PNPS to apparently violate 10 CFR 50.9(a). At this time, the NRC is considering this matter for enforcement. You will be advised by separate correspondence of the results of our deliberations on this matter. No response regarding this apparent violation is required at this time.

You should note that final NRC documents, including the final OI report, may be made available to the public under the Freedom of Information Act (FOIA) subject to redaction of information pursuant to the FOIA. Requests under the FOIA should be made in accordance with 10 CFR 9.23, Requests for Records.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Should you have any questions regarding this letter, please feel free to contact Mr. Richard Conte of my staff at (610) 337-5183.

Sincerely,

/RA/

Wayne D. Lanning, Director
Division of Reactor Safety

Enclosure: Factual Summary - OI Case No. 1-2000-002

cc w/encl:
M. Krupa, Director, Nuclear Safety & Licensing
J. Alexander, Director, Nuclear Assessment Group
D. Tarantino, Nuclear Information Manager
S. Brennion, Regulatory Affairs Department Manager
J. Fulton, Assistant General Counsel
R. Hallisey, Department of Public Health, Commonwealth of Massachusetts
The Honorable Therese Murray
The Honorable Vincent deMacedo
Chairman, Plymouth Board of Selectmen
Chairman, Duxbury Board of Selectmen
Chairman, Nuclear Matters Committee
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* Per E-Mail from J. Dixon-Herrity

Enclosure

FACTUAL SUMMARY - OFFICE OF INVESTIGATIONS CASE NO. 1-2000-002

The NRC Office of Investigations (OI), Region I Field Office initiated an investigation on January 6, 2000, to determine if a Pilgrim Nuclear Power Station licensed reactor operator (RO) falsified readings from a reactor building tour. Based on the evidence developed during this investigation, OI substantiated that the RO knowingly provided incomplete and inaccurate information on licensee records documenting a reactor building tour conducted by the RO on December 8, 1999.

The OI investigation was initiated after the Pilgrim plant manager, on December 11, 1999, informed the NRC resident inspector that a licensed RO toured the reactor building in 26 minutes (based on security card readers), whereas a normal tour routinely took 1½ to 2 hours. The licensee conducted an investigation and determined that the RO falsified operationally significant documents. The RO's employment was terminated on January 7, 2000.

Pilgrim Procedure No. 2.1.16, "Nuclear Power Plant Operator Tour," Revision 95, required operators to tour the reactor building to record values, initials and check marks for systems and equipment, including those required by Technical Specifications such as: (1) Step R99 - record nitrogen flow to the TIP system purge; (2) Steps R114, R115, R116, R155, R156, R157 - record particulate, iodine and gaseous activity values from the C19 West and East Panels, respectively; and (3) Steps R160, R161 - record torus oxygen concentrations. Upon completion of the tour, operators were required to transfer the tour data to Pilgrim Procedure No. 2.1.15, "Daily Surveillance Log (Technical Specifications and Regulatory Agencies)," Revision 120, which was reviewed by the control room supervisor. These readings were also recorded in a computer database.

Regarding (1) above, the RO recorded the exact same value that was recorded the previous day. Therefore, this reading indicated that no nitrogen was used, which was inconsistent with the operating history of the system. The RO also recorded that the reading was taken at 11:00 a.m. However, the security card reader indicated that the RO was not in the reactor building at that time. Because Pilgrim Procedure No. 2.1.15 was blank where this reading was required to be recorded, the control room supervisor later contacted the RO and questioned the blank data field. The RO re-entered the reactor building to obtain another reading. Regarding (2) above, all six readings were identical to the readings taken the previous shift. The operating history of the system would indicate this scenario to be unlikely. Regarding (3) above, in order to take the oxygen concentrations, the control room needed to be contacted so that valves could be opened, which would generate an alarm in the control room. An alarm history report did not show receipt of an alarm nor could any control room personnel recall receiving a phone call from the RO requesting the valves to be opened.

The RO admitted being careless and making mistakes, and that the reactor building tour was not adequate. However, the RO maintained that no information was willfully falsified. The RO told the control room supervisor that a "short tour" had been done, but all required readings were obtained. The RO explained that pressing the enter key while entering data into the computer database may have caused some of the identical readings. The RO also explained that some readings may have been transposed from the previous days' readings. The RO could not explain the lack of an alarm in the control room but insisted that the control room was called to open the valves. The RO believed Pilgrim Procedure No. 2.1.15 was accurate when submitted, other than the missed reading.

When considering the shortness of the tour, seven readings being duplicative from previous readings, a missing data field in Pilgrim Procedure No. 2.1.15, no alarm being generated in the control room, and no one in the control room recollecting a call from the RO to open valves, the totality of the evidence suggests more than a coincidence and refutes the possibility that the RO was just careless. Rather, the totality of the evidence suggests that the RO knowingly provided incomplete and inaccurate information on licensee records documenting a reactor building tour.