March 23, 2005

EA-05-039

Mr. Michael Balduzzi
Site Vice President
Entergy Nuclear Operations, Inc.
Pilgrim Nuclear Power Station
600 Rocky Hill Road
Plymouth, Massachusetts 02360

SUBJECT: NRC OFFICE OF INVESTIGATIONS REPORT 1-2004-040
(Pilgrim Nuclear Power Station)

Dear Mr. Balduzzi:

This letter refers to an investigation initiated by the NRC Office of Investigations (OI), Region I, on August 27, 2004, at Entergy Nuclear Operation's Pilgrim Nuclear Power Station (Pilgrim). This investigation was initiated to determine if a Control Room Supervisor (CRS) at Pilgrim was sleeping/inattentive to duty on June 29, 2004, and whether others were aware that the CRS was inattentive and failed to correct the condition. Based on the evidence developed during the OI investigation, it was substantiated that (1) the CRS was sleeping and inattentive to duty; (2) a Reactor Operator (RO) observed the CRS sleeping but deliberately failed to take immediate action to awaken the CRS, notify the Shift Manager (SM), and write a condition report (CR); and (3) a SM subsequently observed that the CRS was inattentive and failed to fully follow procedures in careless disregard of requirements. With respect to the SM, he did not immediately relieve the CRS of his duties, did not have him for-cause fitness-for-duty (FFD) tested, failed to inform appropriate site personnel, and did not write a CR. Enclosed is a factual summary of the OI investigation that supports the basis for these conclusions.

Based on the results of this OI investigation, the NRC has identified three apparent violations that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600. The current Enforcement Policy is included on the NRC's Web site at www.nrc.gov; select **What We Do**, **Enforcement**, then **Enforcement Policy**. The apparent violations involve failures of the CRS, RO, and SM to follow plant procedures. Specifically, the CRS (who is no longer employed at Pilgrim) was asleep for approximately 4 minutes on June 29, 2004, and was, therefore, neither alert nor attentive to his duties in violation of Pilgrim Procedure 1.3.34, "Conduct of Operations." In addition, the CRS did not ask the SM for relief before or after he was awakened by the SM. The RO (who is also no longer employed at Pilgrim) observed the CRS asleep (an adverse condition) but deliberately failed to take immediate actions to awaken the CRS, failed to inform appropriate site personnel, and failed to initiate a CR in violation of Pilgrim Procedure ENN-LI-102, "Corrective Action Process."

Additionally, after observing the inattentive CRS and taking some immediate actions to correct the situation, the SM (in careless disregard of requirements) failed to immediately relieve the CRS of his duties, did not have the CRS for-cause FFD tested, did not inform appropriate site personnel, and did not initiate a CR in violation of Pilgrim Procedures ENN-NS-102, "Fitness For Duty Program," and ENN-LI-102. Technical Specification 5.4.1 of Facility Operating License No. DPR-35 for Pilgrim Nuclear Power Station requires the establishment and implementation of Pilgrim Procedures 1.3.34 and ENN-LI-102. NRC regulation 10 CFR 26.20 requires implementation of Pilgrim Procedure ENN-NS-102.

Since the NRC has not made a final determination in this matter, no violations are being issued at this time. In addition, please be advised that the number and characterization of these apparent violations may change as a result of further NRC review. You will be advised by separate correspondence of the results of our deliberations on this matter. No response regarding these apparent violations is required at this time.

A closed predecisional enforcement conference to discuss these apparent violations has been scheduled for April 8, 2005, at 10:00 a.m., in the Region I Office in King of Prussia, PA. The decision to hold a predecisional enforcement conference does not mean that the NRC has determined that violations have occurred or that enforcement action will be taken. This conference is being held to obtain information to assist the NRC in making an enforcement decision. This may include information to determine whether violations occurred, the significance of violations, the circumstances associated with the identification of the violations, and corrective actions taken or planned to prevent recurrence. The conference will also provide an opportunity for you to provide your perspective on these matters and any other information that you believe the NRC should take into consideration in making an enforcement decision. Further, you should also be prepared to discuss whether and why the NRC should have confidence that the SM, who is employed at Pilgrim but is not currently performing licensed duties, should return to licensed duties. Finally, we request that you also address actions taken or planned to ensure that all site employees, and operators in particular, will report and document adverse conditions such as inattentive situations among watch standers, when discovered at Pilgrim.

Instead of a Predecisional Enforcement Conference, you may request alternative dispute resolution (ADR) with the NRC in an attempt to resolve this issue. ADR is a general term encompassing various techniques for resolving conflict outside of court using a neutral third party. The technique that the NRC has decided to employ during a pilot program which is now in effect is mediation. Additional information concerning the NRC's pilot program is described in the enclosed brochure (NUREG/BR-0317) and can be obtained at http://www.nrc.gov/what-we-do/regulatory/enforcement/adr.html. The Institute on Conflict Resolution (ICR) at Cornell University has agreed to facilitate the NRC's program as an intake neutral. Please contact ICR at 877-733-9415 within 10 days of the date of this letter if you are interested in pursuing resolution of this issue through ADR.

Please contact Mr. Clifford Anderson at (610) 337-5227 within 10 days of the date of this letter to notify the NRC of your decision to either participate in a Preliminary Enforcement Conference or pursue ADR.

In accordance with 10 CFR 2.390 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/reading-rm/adams.html (the Public Electronic Reading Room). Should you have any questions regarding this letter, please feel free to contact Mr. Clifford Anderson at (610) 337-5227.

Sincerely,

/RA/

A. Randolph Blough, Director
Division of Reactor Projects

Docket No. 50-293
License No. DPR-35

Enclosure: 1) Factual Summary - OI Report 1-2004-040
2) Brochure NUREG/BR-0317

cc w/o encl 2:
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M. Kansler, President, Entergy Nuclear Operations, Inc.
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Enclosure

FACTUAL SUMMARY - OI REPORT 1-2004-040

This investigation was initiated on August 27, 2004, by the Nuclear Regulatory Commission, Office of Investigations (OI), Region I, to determine if a senior reactor operator/control room supervisor (CRS), Pilgrim Nuclear Power Station (Pilgrim), was sleeping/inattentive while on duty in the control room, and whether others were aware of it and failed to act to correct the condition adverse to quality.

Based on the evidence developed during the investigation, the OI investigation concluded that (1) the CRS was sleeping and inattentive to his control room duties for a period of time, (2) there is insufficient evidence to substantiate that the CRS deliberately fell asleep or was intentionally inattentive to duty, and (3) the licensed RO had observed the CRS sleeping on June 29, 2004, but deliberately failed to take immediate action to awaken the CRS, to notify the SM, and to write a condition report (CR), and (4) the SM, in careless disregard of requirements, failed to fully follow procedures regarding the inattentive CRS and the condition adverse to quality that it represented. Although the SM slammed a desk when he observed that the CRS was inattentive, the SM did not immediately relieve the CRS of his duties, have him for-cause fitness-for-duty (FFD) tested, inform appropriate site personnel, and write a CR.

With respect to the CRS, OI concluded that a video taken by the RO provides conclusive evidence that the CRS was asleep for a short period of time on June 29, 2004. Based on various testimony, the length of the video clips, and digital clocks captured in the video clips, the CRS was asleep for approximately 4 minutes. However, there was insufficient evidence to conclude that the CRS deliberately fell asleep or made a conscious decision to become inattentive to duty.

With respect to the RO, OI concluded that the RO made a conscious and deliberate decision to video the CRS sleeping, and during the time that the RO was videoing the CRS, he deliberately did not awaken the CRS and deliberately allowed a condition adverse to quality to continue. In addition, the RO deliberately did not inform the SM of his observation or initiate a condition report (CR) to document the adverse condition. In support of this conclusion, the RO admitted during his interview with OI that he should have awakened the CRS, informed the SM, and written a CR. The RO also testified that he crossed paths with the SM just prior to the SM waking the CRS but chose not to tell the SM what he had observed. He also admitted looking for a CR on the situation when he returned to work about 1 month later.

With respect to the SM, OI concluded that although the SM took immediate actions to end the CRS's inattentive behavior when he slammed a desk, which got the attention of the CRS, and provided counseling to the CRS shortly thereafter; the SM, in careless disregard of requirements, failed to fully follow Pilgrim procedures. When interviewed by OI, the SM testified that he did not observe the CRS asleep; rather, he observed head-bobbing by the CRS. Nonetheless, the SM also testified that the CRS was inattentive and not alert to his duties. The SM further testified that he immediately went over to the CRS and slammed the desk to gain his attention. However, the SM did not immediately relieve the CRS of his duties, did not have him for-cause FFD tested, did not inform appropriate site personnel, and did not write a CR even though the SM was aware of a similar event 2 months earlier in April 2004 when a licensed

operator was found asleep during his lunch period in a break room. After the April 2004 occurrence, all SMs were instructed to emphasize peer checking, alertness, attentiveness, and FFD-related matters to their crews. In fact, the SM testified that he provided this training to his crew. Nonetheless, just 2 months later, this SM did not follow procedures when he observed the inattentive CRS in June 2004. Further, the SM did not inform appropriate site personnel of his observation even though he met with operations management approximately 2 hours after he had observed the inattentive CRS.