

MIDDLE SOUTH UTILITIES, INC./BOX 61005/NEW ORLEANS, LA 70161/(504) 529-5262

FLOYD W. LEWIS
CHAIRMAN/CHIEF EXECUTIVE

August 30, 1979

Mr. Harold R. Denton
Director
Office of Nuclear Regulatory Regulation
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Dear Mr. Denton:

In my letter of August 1, I addressed the short-term recommendations of the TMI Lessons Learned Task Force for a limiting condition for operation of nuclear power plants based upon operational error. At that time, I committed the TMI Ad Hoc Nuclear Oversight Committee to provide you by September 1 a plan designed to meet operational reliability, while protecting from unnecessary plant shutdowns the customers served.

Current operations for nuclear power plants are governed by Technical Specifications that require shutdown of a plant upon loss of a safety system, whether from operational errors or for other reasons such as equipment failure. The Technical Specifications also prescribe reporting requirements for such situations. It is felt that operation in accordance with Technical Specification requirements as presently conceived should remain the criteria for plant operation with additional actions as discussed below.

The NRC Task Force's recommendations regarding shutdown of a plant upon loss of a safety system, whether from operational errors or for other reasons such as equipment failure, are not practical or in the public interest. In an effort to assure attention by senior utility management, they could penalize electrical users by requiring shutdown even if a safety function has been restored. Written alternative corrective actions as the NRC Task Force proposes may not be necessary. The proposed public meeting is impractical, not because of disclosure but because of notice requirements and other formalities including unnecessary loss of electrical production. This is not to say, however, that the licensee should not itself review each loss of safety function at each operating plant and also review them with the Regional compliance office.

We would propose additional actions as hereinafter set forth. To assure that the Nuclear Regulatory Commission and corporate management are being made aware of any operating condition affecting a safety function's operability, plant management would, on complete loss of operability of a safety function due to operational

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error, make an immediate report to their Regional Inspection and Enforcement (I&E) office. Concurrently, that corporate officer having responsibility for nuclear power generation would also be notified. That corporate officer, or his superior, would then make a prompt (as defined in Regulatory Guide 1.16, paragraph C2.a.) notification to the Regional I&E Director to confirm the reported event. This notification would also include a discussion of the short-term corrective action being taken to assure the safe operation of the plant.

Upon a complete loss-of-safety function due to operational error, the licensee would be required to conduct an investigation as to the cause of the incident and institute corrective action. Within 14 days of the incident, if requested, a meeting with the NRC Regional I&E Staff would be convened where the corporate officer responsible for nuclear power generation would provide both orally and in writing the results of its investigation. The investigation would include as a requirement for review the deliberations of a special designated off-site safety review task force. The designated task force would conduct an investigation of the incident, as well as the action taken by the plant management. It would then make its recommendation to senior corporate management of any additional action that should be taken by the individual plant, or state that the action taken was of a nature to reduce the possibility of this type of incident happening again. Also, adding further support to the independence of the investigation, the Resident Nuclear Regulatory Inspector assigned to that particular plant (if one has been assigned) could audit and evaluate management's action.

If the cause of the incident is attributed to one or more individuals, it could be cause for retraining or it may indicate need for disciplinary action by the licensee. Since there may be a number of diverse causes for the incident, we would expect the remedial action would and should be different for each situation and the same prescribed action may not be followed.

In summary, the following procedures are proposed for the complete loss of a safety function due to an operational error:

1. Plant Manager or in his absence his designated representative, make an immediate report to their Regional Inspection and Enforcement Office.
2. Plant Manager, or in his absence his designated representative, would immediately notify that corporate officer responsible for nuclear power generation of the event.
3. Corporate officer responsible for nuclear power generation, or his superior, will confirm the event to the Regional I&E Director and describe short-term corrective action.

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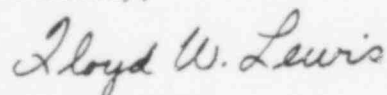
4. An off-site investigative task force would be designated and they would promptly review the event and propose corrective actions. If the cause of the incident is attributed to one or more individuals, it could be cause for retraining or it may indicate need for disciplinary action by the licensee.
5. Within 14 days, if requested, the corporate officer responsible for nuclear power generation would meet with the Regional I&E Director to provide oral and written results of the investigation.

The actions outlined are not meant to preclude the licensee's option to shutdown the plant or the NRC's option to order the plant shutdown.

We believe the approach to loss of safety function described above satisfies the concerns identified in NUREG 0570, while not imposing an additional hardship upon the consumers of a particular utility of paying an unnecessary cost for replacement power while this type of investigation is being conducted.

Members of the TMI Ad Hoc Nuclear Oversight Committee would be pleased to meet with you or with members of the Office of Standards Development to discuss implementing details of our proposed alternative.

Sincerely,



Floyd W. Lewis
Chairman, TMI Ad Hoc Nuclear
Oversight Committee

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cc: Office of Standards Development

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