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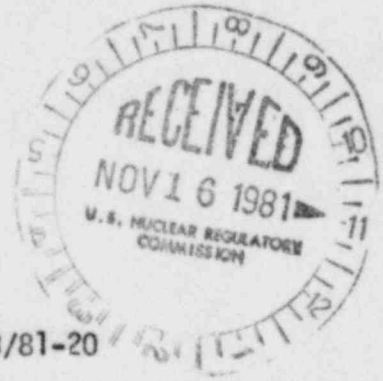
Docket No. 50-293

Boston Edison Company
ATTN: Mr. A. Corey
Senior Vice President
Operations and Engineering
800 Boylston Street
Boston, MA 02199



Gentlemen:

Subject: Performance Appraisal Inspection 50-293/81-20

This refers to the Performance Appraisal Inspection conducted by Mr. C. R. Oberg, and members of the Performance Appraisal Section, Office of Inspection and Enforcement, on July 20-31 and August 10-14, 1981, of activities authorized by NRC Operating License DPR-35 for the Pilgrim Nuclear Plant. This also refers to the observations discussed with you or other members of your staff on July 30 and August 14, 1981, at the Boston Edison Company corporate offices.

This inspection is one of a series of Performance Appraisal inspections being conducted by the Office of Inspection and Enforcement. The results of these inspections are used to evaluate, from a national perspective, the performance of your management control programs in support of Nuclear Safety.

The enclosed report 50-293/81-20 identifies the areas examined during the inspection. Within these areas, the inspection consisted of a comprehensive examination of your management controls over licensed activities which included examination of procedures and records, observations of work activities, and interviews with management and other personnel.

While the enclosed report includes observations which may result in enforcement actions, these matters will be followed by the IE Regional Office. The enclosed appraisal report also addresses other observations and the conclusions made by the team for this inspection. Section 1 of the report provides further information regarding the observations and how they will be utilized. Appendix A to this letter is an Executive Summary of the conclusions drawn for the eight functional areas inspected.

Of the eight areas inspected and evaluated, two areas were considered average; however, significant weaknesses were identified in these areas which will require management attention. Six areas were considered below average. These were the areas of committee activities, quality assurance audits, maintenance, corrective action systems, licensed and non-licensed training, and procurement.

OFFICE ▶						
SURNAME ▶	8112030603 810914 PDR ADOCK 05000293 Q PDR					
DATE ▶						

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Commendably, the team noted strong attention was provided by Boston Edison Company top management to those aspects of Pilgrim's operation associated with maintaining on-line electrical production. However, similar attention was not being provided to important areas of management controls which contribute to assuring public health and safety and which were found to be generally below average at Boston Edison. This unbalanced approach within top management was emphasized by NRC at the exit briefing and will be discussed at a meeting with senior Boston Edison Company management to be arranged by the NRC Director, Region I.

As a result of the significant weaknesses identified in the six areas rated below average, you are requested to inform this office within 30 days of receipt of this report of the actions you have taken or plan to take to improve the management controls in these areas. Your response to this office and your actions regarding identified weaknesses will be followed by the Region I NRC Office.

In accordance with 10 CFR 2.790 of the Commission's regulations, a copy of this letter and the enclosed inspection report will be placed in the NRC's Public Document Room. If this report contains any information that you believe to be exempt from disclosure under 10 CFR 9.5(a)(4), it is necessary that you (a) notify this office by telephone within seven (7) days from the date of this letter of your intention to file a request for withholding; and (b) submit within twenty-five (25) days from the date of this letter a written application to this office to withhold such information. If your receipt of this letter has been delayed such that less than seven (7) days are available for your review, please notify this office promptly so that a new due date may be established. Consistent with Section 2.790(b)(1), any such application must be accompanied by an affidavit executed by the owner of the information which identifies the document or part sought to be withheld, and which contains a full statement of the reasons on the basis which it is claimed that the information should be withheld from public disclosure. This section further requires the statement to address with specificity the considerations listed in 10 CFR 2.790(b)(4). The information sought to be withheld shall be incorporated as far as possible into a separate part of the affidavit. If we do not hear from you in this regard within the specified periods noted above, the report will be placed in the Public Document Room.

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/S/

Norman C. Moseley, Director
Division of Program Development
and Appraisal
Office of Inspection and Enforcement

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Enclosures:
1. ~~IE Management Appraisal Report 50-293/81-20~~
2. Appendix A - Executive Summary

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DATE	9/14/81	9/14/81	9/14/81	9/14/81	9/15/81		

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Appendix A

Executive Summary

A team of five NRC Inspection Specialists from the Performance Appraisal Section conducted an announced inspection at the Pilgrim Nuclear Power Station and Boston Edison Company corporate offices during the period July 20 - August 14, 1981. Management controls in eight areas were inspected. Of these, two areas were considered average and six areas were considered below average.

The numerous below average areas appeared to be the result of several factors, all affecting the existing management control systems. First, the Performance Appraisal Team found that management personnel were lacking in knowledge and understanding of the extent of their quality assurance program responsibilities. Thus there was limited management oversight and involvement in the control of activities in this area. This was aggravated by a reluctance of some management personnel to cross over the established and traditional lines of communication and organization. Conflicts between groups were also identified that apparently were the direct result of a failure to communicate and bridge differences in the support of a common goal.

Second, there was a lack of written policy involving training of personnel at corporate and site levels. Other written program deficiencies were identified.

Third, there appeared to be a lack of emphasis by management to correct problems by the identification of generic causes and subsequent management follow-through to ensure effective corrective action. There was rapid response to some of the deficiencies identified during the PAS inspection; however, many of the problems identified had been previously reported to the licensee by QA audits and NRC inspections but were not corrected. It was noted that training record deficiencies were corrected before the end of the PAS inspection. This was a result of licensee commitments that were identified in an Immediate Action Letter (IAL) issued by Region I on July 31, 1981.

And, finally, there was the apparent goal of top management to achieve superior on-line time at Pilgrim and gain national recognition of that accomplishment. While this is a legitimate objective, the results of such a course of action, untempered by safety considerations in the form of effective management controls could be detrimental to the health and safety of the public.

Balanced against these problems, the Performance Appraisal Team found that management had realized that resources must be provided to ensure that the plant will operate safely as well as effectively. The team identified positive steps that had been taken in providing additional training instructors, additional personnel in the reactor operator qualification pipeline, plans for enlarging the QA staff, and an improved maintenance control system. These positive steps had partially resulted from a reorganization and a change in some management positions.

The team also noted that some of these reasons for below average performance were recognized by the licensee, and there were corrective actions and plans in various stages of implementation.

The following information is a summary of the inspection results of the individual areas.

Committee Activities: Below Average (Section 2). The significant weaknesses of the onsite Operations Review Committee were an inadequate charter and failure to review internal audit reports, NRC Inspection Reports and responses thereto, NRC Bulletins and Circulars, and the Fire Protection Plan. For the Nuclear Safety Review and Audit Committee, the significant weaknesses were an inadequate charter, lack of awareness of committee responsibilities by committee members, and failure to review internal audit reports.

Quality Assurance Audits: Below Average (Section 3). The most significant weaknesses could be divided into three broad categories: failure to implement the program, failure of management to be responsive to and support the program, and program inadequacies.

In the first category, the licensee failed to meet schedule requirements such as issuing various reports, verifying corrective action on outstanding deficiencies, and performing all the required audits. Also there was the failure to perform trend analyses, an inadequate scope on corrective action audits, and failure of the Nuclear Safety Review and Audit Committee to perform adequate reviews of the program, audit reports, and deficiencies.

In the second category, management failed to respond to QA's need for resources to complete program requirements. They failed to take action to resolve serious deficiencies in a timely manner, to encourage staff members to be responsive to resolving deficiencies, and to create a healthy, constructive atmosphere between QA and the staff.

The third category had one significant weakness: an inadequate method to escalate and resolve serious or controversial deficiencies.

The strengths of the program included the excellent depth of audits and surveillance inspections, the use of "Technical Specialists" to augment the audit staff for their technical expertise on certain audit subjects, and a positive attitude toward correcting problems identified by the Performance Appraisal inspection. With the corrective actions in place at the conclusion of the inspection and the proposed corrective action discussed by the licensee representatives, the QA audit program should be improved.

Design Changes and Modifications: Average (Section 4). The licensee had established and implemented a program to control safety-related design changes and modifications. The Nuclear Operations Support Department appeared to be effective in managing and coordinating preparation and

implementation of design change requests. The design phase performed by Nuclear Engineering Department was well documented. Significant weaknesses identified were the untimeliness of initiation of closeout upon completion of design change, the large backlog of drawings pending revisions, and the lack of a written system to ensure that operators had been trained and applicable procedures revised or written prior to design change closeout or system operation.

Maintenance: Below Average (Section 5). An approved procedure for the control of maintenance activities had been implemented. This procedure was well defined and broad in scope. All maintenance was performed and controlled by use of maintenance requests. Significant weaknesses in the overall maintenance program, however, were identified: lack of a meaningful, integrated preventive maintenance program; lack of written administrative procedures for control of as-built drawings and control of vendors manuals; lack of an effective training program for maintenance personnel; and the large backlog of low priority maintenance requests.

Review of Licensed Activities (Plant Operations): Average (Section 6). The significant deficiencies were: a failure to communicate adequately with nonsupervisory operating personnel; failure to perform trend analyses on Failure and Malfunction Reports and Licensee Event Reports; failure to involve reactor operators and supervisors in the review and revision of plant procedures; and failure to provide adequate training on plant modifications.

Corrective Action Systems: Below Average (Section 7). The weaknesses in this area involved a lack of an adequate program, failure to implement the existing program, and inadequate training on the existing program. The most significant weaknesses included failure to have either a software oriented corrective action system or a system that included such items; inadequate training on existing systems, failure to perform trend analyses on reported deficiencies; failure to have adequate followup on corrective actions, including QA verification and committee reviews; and poor documentation on deficiency reports and logs.

Training: Below Average (Section 8).

(1) Licensed Training: Significant problems were identified in the Reactor Operator and Senior Reactor Operator training and qualification records. Training was conducted using a training manual that had not been reviewed by the Operations Review Committee. The training manual, which was the basis of the training program, was not adequately controlled, and lacked key parts of the current training program. The licensee training course did include the requirements of 10 CFR 55 and ANSI/ANS 3.1. While there was a shortage of instructor personnel to adequately carry out the training program, plans existed to increase the size of the training staff. Of primary importance was the lack of adequate management attention as evidenced by the lack of a definitive training policy issued at the corporate level.

(2) Non-Licensed Training: Deficiencies were identified in the non-licensed training program both at corporate level and onsite. Although the basis for a comprehensive training program was in existence, it was lacking direction from management and in most areas was not effectively implemented. Some recent improvements initiated by corporate personnel had improved the quality and quantity of training provided. The primary cause of problems appeared to be the lack of management policy and followup.

Procurement: Below Average (Section 9). The written program for procurement, receiving inspection, and storage was inadequate. There was a lack of awareness, training, and implementation of the written program. Specific examples of improper storage of safety-related materials were identified.