

I. General

The licensee implemented a major organizational and personnel change toward the end of the evaluation period, in September, 1980. These changes were designed to strengthen management controls and improve overall plant operations.

Since the SALP management meeting on March 11, 1981, the licensee took a number of other actions to improve performance. Major efforts include the hiring of consultants to assist in revising work control programs and the development of a computer based system to track action items and commitments. There is also evidence of more thorough reviews of plant events to determine root causes, increased review and revision of operating procedures, and increased training effort.

II. Specific

Contention

"The Pilgrim facility displayed evidence of weaknesses in five functional areas. These areas were: refueling, reporting, radiation protection, emergency preparedness, and management controls."

These contentions are addressed as follows:

- Refueling (See Contention A)
- Reporting (See Contention B)
- Radiation Protection (See Contention C)
- Emergency Preparedness (See Contention D)
- Management Controls (See Contention E)

Contention A

"Weaknesses in refueling activities were characterized by several items of noncompliance, including escalated enforcement, concerning movement of fuel without secondary containment integrity and inadequate corrective actions for identified procedure discrepancies."

1. Basis

On March 8, 1980, irradiated fuel was moved within the spent fuel pool without secondary containment integrity. This event exceeded a Limiting Condition for Operation. The activity was conducted without the consent of the Watch Engineer which is in violation of station fuel handling procedures. In addition, the auxiliary electrical system, including emergency power, was aligned other than as prescribed by plant procedures.

Reference

IE Report
50-293/80

As a result of previous fuel handling errors experienced in December, 1979, procedure revisions were necessary to prevent recurrence. However, an inspection conducted in January, 1980 identified that the required revisions to the procedure were not yet made. These procedural discrepancies, however, did not contribute to the problems experienced on March 8, 1980.

IE Report
50-293/80-09

2. NRC Action

The inspection following the March 1980 event identified four items of noncompliance, two of which are directly related to refueling operations: moving fuel without secondary containment in effect; and, failure to follow a refueling procedure requiring the consent of the Watch Engineer.

IE Report
50-293/80-09

An Immediate Action Letter was issued confirming the licensee's commitments to perform prompt corrective action.

3/11/80 NRC
Region I
letter
(IAL 81-07)

A followup inspection was performed in April, 1980. No items of noncompliance were identified.

IE Report
50-293/80-13

A civil penalty was imposed in April, 1981 for the March 1980 event.

NRC letters
7/8/80,
10/30/80 and
4/21/81.
EA80-38

3. Licensee Corrective Action

When the licensee recognized the violation on March 10, 1980, further fuel movement was immediately suspended and a prompt report was made to the NRC.

IE Report
50-293/81-09

In response to the items of noncompliance, the licensee revised procedures, performed additional training, and increased management control of refueling activities.

Licensee
letters of
8/1/80 and
11/19/80.

Contention B

"The licensee had cases of inadequate Licensee Event Reports and responses to IE Bulletins."

1. Basis

References

This weakness is symptomatic of improper management controls which is discussed in Contention "E".

Problems with LER's more closely linked to improper management controls are, therefore, addressed therein. Three areas are discussed below which categorize some of the other problems associated with improper licensee reporting.

a. The licensee identified that the following reports were not made within the required time frame:

- . Failure to report Reactor Scram LER 80-26
- . Condenser delta T limit exceeded LER 80-74
- . Fire Detection Equipment Inoperable LER 80-75

b. The resident inspector discovered that an APRM instrument setpoint drift had not been reported to the NRC as required. This event resulted in an item of noncompliance. IE Report 50-293/80-

c. Licensee written responses to I.E. Bulletins did not always fully address NRC concerns or were not entirely accurate. This resulted in requests from the NRC for additional information, action, and revised responses. Examples of inadequate responses to I.E. Bulletins include:

IEB 79-27 - Loss of Non-Class 1-E Instrumentation and Control Power System Bus During Operation

Because of inadequate initial response, the licensee was required to submit an additional response to item 2 of this bulletin to address: IE Report 50-293/80-

- plans for making changes to existing procedures
- plans for providing additional procedures for previously existing equipment and newly installed alternate control shutdown panels
- a proposed schedule for completing these items

IEB 80-14 - Degradation of BWR Scram Discharge Volume Capacity

Item 3 of this bulletin required that facility procedures specify certain requirements for SDV vent and drain valves. The licensee's response did not address those requirements. IE Report 50-293/80-

IEB 80-07 - BWR Jet Pump Failure

The licensee's surveillance procedure for taking data to identify jet pumps degradation did not include all of the data required by the Bulletin.

IE Report
50-293/80-27

2. NRC Action

In each instance where an inadequate report was identified, the licensee was required to take corrective action as appropriate, and the resident inspector followed the progress of that action.

Enforcement action was taken for identified items of noncompliance.

3. Licensee Corrective Action

At the SALP Management Meeting, senior licensee management expressed concern over past reporting deficiencies, and expressed a desire to improve their communications with the NRC.

The licensee developed a computer tracking system to commitments to the NRC, which includes reports.

Reports and responses to the NRC issued from the corporate offices are now reviewed by station management for accuracy prior to being released by the corporate office.

Contention C

"The Radiation Protection Program was characterized by numerous items of noncompliance and program weaknesses, many of which were identified during the health physics appraisal team inspection."

1. Basis

The Health Physics Appraisal in January 1980 identified several weaknesses in the Internal Exposure Control Program and the personnel selection and training program. Examples of these weaknesses included: the lack of a technically knowledgeable individual assigned to the Internal Exposure Control Program; weakness in personnel training and qualifications; lack of procedures; lack of adequate facilities; lack of in-plant surveillance; and failure to ensure consideration of engineering controls. Additionally, there were no formal training or retraining pro-

References

IE Reports
50-293/80-0
and 80-29

grams for members of the plant health physics staff and minimal effort was exercised to determine the qualifications of contractor supplied health physics personnel.

The Health Physics Appraisal identified seven items of noncompliance with regard to the requirements of 10 CFR Parts 20 and 50, and the Technical Specifications. Examples included: failure to perform evaluation and surveys of airborne radiation areas; personnel exceeding the 40 hour control measure for airborne radioactivity; MPC hour determinations not being performed for personnel in high airborne radioactivity areas; intake of radioactive material evaluations not being performed; and, failure of the licensee to properly post and control entry into high radiation areas.

2. NRC Actions

A management meeting was held on March 11, 1981 at which time the weaknesses and items of noncompliance were addressed. A special inspection to followup on the Health Physics Appraisal is scheduled for August 1981.

IE Report
50-293/81-09

3. Licensee Corrective Action

The licensee took corrective actions in response to the items of noncompliance identified in IE Reports 50-293/80-05 and 80-29. The licensee committed to develop a formal training/retraining program for health physics personnel. Staff members received formal training on internal dosimetry and are re-evaluating the internal exposure control program. Necessary equipment was ordered; procedures are being revised or developed as the situation dictates.

Licensee
letters of
8/29/80,
2/5/81 and
5/11/81.

Contention D

"Escalated enforcement was taken to correct identified weaknesses and inadequacies in several emergency response procedures."

1. Basis

The HP Appraisal inspection of January, 1980 also included a review of the licensee's Emergency Preparedness. Several deficiencies associated with the licensee's ability to organize and mobilize personnel in the event of an emergency were identified.

References

Report
50-293/80-05

The present equipment configuration for emergency environmental monitoring in conjunction with existing procedures were found to be inadequate since there was an inability to detect, measure and project radiation levels and radionuclide concentrations in air equivalent to the lower limits of the Protective Action Guides.

The procedures for declaring an emergency were based solely on the results of a rapid protected area survey. The survey method was inadequate and dependence upon it was considered unacceptable.

Several emergency plan implementing procedures were found to be outdated due to changes in personnel and facilities.

The emergency plan training program, as written in the Pilgrim Station Training Manual, was not being implemented. The 1979 radiation emergency plan training was not performed in accordance with the training manual.

The state of readiness of emergency equipment appeared to indicate some maintenance problems, e.g., items missing and out of calibration.

There was a lack of clear assignment of emergency duties and responsibilities for radiation protection and emergency repair/corrective actions.

Subsequent to this evaluation period, a regional inspection following up on a resin spill of January 17, 1981, indicated that the licensee failed to take adequate action to implement interim corrective measures addressing radiation protection during emergencies which were previously identified in the January, 1980 HP Appraisal. Neither routine nor emergency procedures addressed the special considerations for preventing or limiting exposures during emergency situations.

IE Report
50-293/81-04

2. NRC Action

An Immediate Action Letter was issued in February, 1980, to confirm the licensee's commitments to correct the concerns identified in the HP Appraisal.

2/27/80 NRC
Region I
letter
(IAL 80-06)

A special regional inspection was performed in May, 1980 to confirm implementation of the licensee's commitments.

IE Report
50-293/80-23

An Immediate Action Letter was again issued in February, 1981, to confirm the licensee's commitment to correct items identified as a result of the resin spill event.

2/10/81 NRC
Region I
letter
(IAL 81-09)

3. Licensee Corrective Action

The licensee revised procedures, conducted training and procured additional equipment in response to the IAL of February 27, 1980.

IE Report
50-293/80-23

The licensee committed to revising additional procedures, conducting additional training, and updating system drawings.

IE Report
50-293/81-04;
2/10/81 NRC
Region I
letter
(IAL 81-09)

Contention E

"Licensee management control weaknesses were indicated by inadequate evaluation of several events to prevent recurrence, instances of inadequate corrective actions, and instances of inadequate implementation of commitments made to the NRC."

1. Basis

References

Two items of noncompliance were identified which related to inadequate management controls: failure to provide a station procedure for operation of the electrical distribution system with the auto-close feature of the EDG output breakers defeated; and failure to ensure that no maintenance was performed after the containment inspection prior to the Containment Integrated Leak Rate Test.

IE Reports
50-293/80-09
and 80-20.

At least six LER's issued by the licensee during the evaluation period identify inadequate management controls. In LER 80-36, licensee management failed to insure that hourly fire watch tours were performed as required for inoperable smoke detectors. Another example is LER 80-39, wherein the product of APRM instrument tolerance limits permitted prior to recalibration allowed the setpoint to drift beyond the required Technical Specification limit. Adequate management control would have prevented this situation.

LER Numbers
80-23, 80-36
80-39, 80-50
80-68 and
80-72.

A review of many LER's indicated lack of thoroughness in evaluating failures to prevent similar causally-linked events. This is indicated by the number of events, similar and recurrent, which list only replacement or repair of a failed component as corrective action without pursuing the cause for the failures. This problem is demonstrated by LER's 80-63 and 80-77. In LER 80-63, it was reported that the containment atmosphere sampling system was declared inoperable due to moisture in the line. The cause of the moisture was corrected; however, action was not taken to prevent moisture accumulation from rendering the system inoperable. The same problem was again reported in LER 80-77. Following this second occurrence, management took action to insure proper system operation even in the event of moisture accumulation.

LER's/
(Earlier
Related
LER'.)
80-18, 80-41
(79-38,
79-42),
80-25 (79-52)
80-65 (80-33)
80-86 (79-53,
80-74)
80-79 (80-47)
80-80 (80-69)
80-60 (80-58)
80-53 (80-34)
80-77 (80-63)
80-59 (Amend.
42 to Tech.
Specs.)
80-61, 80-93
(80-45)
80-21, 80-31,
80-42, 80-92
(80-09)

Approximately 50% of the LER's issued during this evaluation period list 'other' as the cause. This cause is chosen over personnel error, manufacturing/construction/installation error, external causes, defective procedures, and component failure. This large percentage listing 'other' as the cause may indicate inadequate review to determine the root cause and possibly could hinder appropriate corrective actions being recommended to prevent recurrence.

All 1980
LER's

As a result of inadequate management control, several licensee responses/actions taken as a result of IE Bulletins did not address all specific areas of concern. This resulted in requests by the NRC for additional information, action, and/or revised reports. Specific examples were previously discussed in Contention "B".

IE Reports
50-293/80-24,
80-25, 80-26,
80-27 and
81-02

The licensee's management controls for followup and implementation of commitments made to the NRC were found to be inadequate. The licensee did not implement commitments made concerning the TMI Task Action Plan; specifically, limiting overtime hours of operators; and, limiting total times for operation

IE Reports
50-293/80-29,
80-30;
11/18/80 NRC
Region I
letter (IAL

of the containment vent and purge system.

80-40)
11/28/80
NRC Region I
Letter
(IAL 80-50)

2. NRC Action

An item of noncompliance resulted in the imposition of civil penalties issued as a result of the fuel handling incident of March, 1980. This was previously discussed in Contention "A".

NRC letters
of 7/8/80,
10/30/80 and
4/21/81.

Two Notices of Deviation were issued for failure to meet commitments.

IE Report
50-293/80-30

Immediate Action Letters were issued to confirm licensee's commitments to correct three TMI items, and control overtime for operators.

11/18/80 NRC
Region I
letter (IAL
80-49);
11/28/80 NRC
Region I
letter (IAL
80-50)

At the SALP management meeting held in March, 1981 the concerns in the area of management controls were reviewed in depth with the licensee.

IE Report
50-293/81-06

3. Licensee Action

The licensee responded to the identified items of noncompliance and deviations with actions designed to correct the specific deficiency and to prevent its recurrence. This consisted primarily of revising procedures where required, and properly training personnel.

In addition, a major reorganization and personnel change was effected on September 1, 1980. The (old) position of Nuclear Operations Department Manager (offsite) was deleted. A (new) position of Nuclear Operations Manager - Pilgrim Station (onsite station manager) reports directly to the VP-Nuclear. Two Deputy Nuclear Operation Managers were assigned in place of the previous Assistant Station Manager. The previous staff under the former NOD Manager was reorganized into a separate Nuclear Operations Support (NOS) Department. Additional staff assistants to the Station Manager were added. The HP staff was also expanded to include an ALARA group.

LER 80-54

These changes were made to strengthen management controls and improve overall plant operations. Daily staff meetings are held onsite with senior supervisors on a regular basis to discuss plant status and problems. Onsite Review Committee meetings are usually held once per week.