SALEM 1 AND 2 Evaluation Period: 9/1/79-8/31/80

I. General

The licensee reorganized the corporate management structure to improve, focus and strengthen management involvement in nuclear activities. Line responsibilities for the licensee's nuclear and fossil facilities were separated and a separate General Manager was provided for each facility type. This separation allowed the General Manager-Nuclear Production to devote total attention to nuclear facility activities. The General Manager for Corporate Quality Assurance now reports directly to a Senior Vice President and the Station Quality Assurance staff reports to the Corporate Manager - QA Operations and Maintenance. Realignment of the QA chain of command has increased the independence between station QA activities and plant operations.

The licensee revised the station Security Plan and took action to upgrade the quality of the guard force. In addition the licensee took action to improve the timeliness and accuracy of reports to the NRC by appointing an individual to control and coordinate this activity.

II. Specific

Contention

"The Salem facility displayed evidence of weaknesses in four functional areas. These areas were plant operations, reporting, security and safeguards, and management controls."

These contentions are addressed as follows:

Plant Operations (See Contention A)
Reporting (See Contention C)
Security and Safeguards (See Contention D)
Management Controls (See Contention E)

Contention A

"Weaknesses in plant operations were characterized by instances of failure to operate in accordance with plant procedures and instances of violation of Technical Specification limitations."

1. Basis

During the evaluation period several non-compliances were identified in this area, principally as a result of failure to follow procedures. Specific examples included: failure to follow procedures relative to valve position; simultaneous tagout of all emergency diesel generators; entry into

IE Reports 50-272/79-28, 80-05, 80-06, 80-12, 80-20

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operational mode without complying with T.S. Limiting Conditions for Operation; failures to follow operating procedures (2 events); exceeding licensed power limits; and failure to follow procedures relative to logs and tagging. Inspection results and licensee reported events indicate a lack of operator attention to T.S. limits and procedural requirements.

LERS 79-71, 79-76, 80-19, 80-20, 80-43

2. NRC Action

An IAL was issued on November 1, 1979 after the inspector identified valve alignment errors. The IAL required independent verification on all safety-related systems prior to achieving Hot Shutdown conditions; establishment of positive means to ensure that all personnel with access to safety related equipment are aware of requirements relative to valve status and operations; and strengthened control of valve alignments.

11/1/79 NRC Region I letter (IAL 79-16)

A notice of violation was issued by IE HQ as a result of LER 79-71 that reported a case where all diesel generators were put out of service due to a tagging error.

LER 79-71 2/11/80 NRC Letter

Increased inspection by the resident inspectors has identified one item of noncompliance for failure to recognize operation in a degraded mode. The increased effort also has focused the licensee's attention on this area. Inspection results indicate that the degree of attentiveness to operational situations and initiation of prompt corrective action has demonstrably improved.

IAL 79-16 50-272/81-01 80-20, 80-23, 80-32, IE Report 50-272/80-26

3. Licensee Corrective Action

The Licensee has taken corrective action to address each specific item of noncompliance identified by the NRC. Examples include: establishing an independent verification of valve lineups for systems covered by T.S. (complete 1/1/80); reinstruction of personnel in their responsibilities concerning valve alignments; implementation of a computerized system to include operational mode changes, component status verification, and warning printouts for T.S. limits (in preoperational

Licensee letters dated: 1/22/80 4/10/80 3/6/80 7/2/80 10/10/80

testing phase); counseling of individuals involved in personnel errors; allowing only shift supervisors (SRO) to authorize the placement or removal of tags; retraining of licensed and non-licensed personnel in tagging activities and responsibilities; and, establishment of a semi-annual review of tagging procedures and effective tagouts.

Contention B

"There were reported cases where the licensee failed to complete required surveillance tests." (See contention A, above, and contention E, below)

Contention C

"Licensee reports were late, inaccurate, or incomplete on several occassions."

1. Basis

Inspection by the resident inspectors identi- problems concerning timeliness, accuracy, and completeness of licensee event reports and licensee action regarding IE Bulletins and responses to the NRC. Examples of incomplete or inaccurate responses include: IE Bulletins 80-05, 80-20, 80-11, 80-15, Lessons Learned responses relative to PORV limit switches and plant vent monitor.

References

LERs Unit 1
80-04, 79-57,
80-41
LER's Unit 2
79-25, 79-67
79-59
IE Reports 50-272/80-13, 80-20
80-21, 80-23 and
50-311/80-03

2. NRC Action

The NRC has communicated its concerns regarding reporting to the licensee during routine meetings between the NRC resident inspectors and the licensee and during the SALP management meeting on October 23, 1980. Timeliness and quality of licensee submittals was further discussed during meetings between the licensee and the resident inspectors and Region I management at various intervals. The NRC continues to monitor licensee performance in this area.

References

IE Report
50-272/80-26
and 50-311/80-19

3. Licensee Corrective Action

The licensee has taken action to improve performance in this area, including assigning responsibility for the coordination and control of reporting activities to a single individual onsite.

Contention D

"The Salem facility displayed evidence of weakness in ...security and safeguards... There were problems in maintaining security controls between Unit 1, which was operating, and Unit 2, which was still under construction and subject to different security requirements than an operating facility."

1. Basis

The NRC identified problems in the security area which resulted from inadequate control and construction of vital area barriers, failure to follow procedures and failure to provide adequate access control.

There were several events which occurred involving the control and construction of vital area barriers. Examples include: the NRC finding an interface door between Unit Nos. 1 and 2 not guarded and not barricaded, allowing unimpeded access to at least three vital areas in the Unit 1 Auxiliary Building (August 28, 1979); a similiar event, occurring in September, 1979, involving another security door in the interface wall between Unit Nos. 1 and 2; and, on September 30, 1979, the NRC finding floor plates removed in the Unit 1 Auxiliary Building (a vital area) which permitted unimpeded access to other vital areas.

IE Report
50-272/79-26

As a result of a subsequent inspection on July 14 thru 18, 1980 additional problems involving the construction of vital area barriers were identified. An opening sized in excess of requirements was observed in the wall of the control room (a vital area) and an opening sized in excess of requirements was observed above the main door of the Auxiliary Building (a vital area).

IE Reports
50-272/80-17
50-311/80-13

In three physical security inspections, there were several events which involved failure to follow the procedures implementing the physical security plan. Examples include: failure to adequately provide continuous visual surveillance to a vital area barrier during the period February 27, 1979 to August 26-27, 1979; and failure to isolate the individual responsible for the badge passout and last access control function in a bullet resistant structure.

IE Report
50-272/79-26

During the security inspection conducted Janaury 21-25, 1980 NRC noted that the licensee failed to assign watchmen ely to watchmen duties; failed to forward appropriate changes to the Security Plan to NRC HQ for approval; and failed to revalidate the need for continued unescorted access to vital areas every 31 days.	IE Report 50-272/80-02
In another instance, on July 16, 1980 the licensee failed to maintain the isolation zone free of materials or obstructions which could provide cover and concealment.	IE Report 50-272/80-17 50-311/80-13

2. NRC Action

Following the August 28, 1979 and September 30, 1979 events discussed in 1 above, the NRC conducted a significant licensee meeting on February 26, 1980 regarding the limited management controls of the security organization identified in a pending escalated enforcement action.	IE Report 50-272/80-09
Following the February 26, 1980 management meeting which covered other subjects as well as security, another management meeting was conducted on April 18, 1980 which dealt with the NRC intent to issue an Order to Modify the Facility Operating License.	IE Report 50-272/80-12
On March 20, 1980, the NRC imposed a civil penalty covering the events occurring between August 28 and September 30, 1979. In addition, an Order to Modify the Facility Operating License was issued in conjunction with the civil penalty requiring the adoption and implementation of written security procedures requiring the continuous visual surveillance of the interface wall, review existing security procedures and controls, and the submission of special security procedures which would address problems identified in the civil penalty.	3/20/80 NRC Letter
The NRC issued Notices of Violation addressing the other problems identified by security inspections. The NRC continues to monitor licensee corrective actions in the security area.	3/20/80 NRC letter; IE Report 50-272/80-02

3. Licensee Corrective Action

To resolve the events involving vital area boundary control that occurred between August 28, 1979 and September 30, 1979 and for which a civil penalty and an Order to Modify the Facility Operating License were subsequently issued. The licensee discontinued using the interface between Unit Nos. 1 and 2 as vital area barriers; brought vital area key control under the exclusive domain of the security organization; and expanded the protected area barrier to encompass all of the buildings in Units 1 and 2 within the confines of a single barrier. The redefinition of the protected area obviated the need for additional patrolling or controlling of access inside the Auxiliary Building of each facility. In addition, the licensee significantly increased Security Force compensation (increased pay and allowances) to increase the caliber of individuals hired and to demand a higher level of performance.

4/14/80 Licensee Ltr.

In regards to corrective action relative to the use of watchmen, the licensee changed the Security Plan allowing more flexibility in the use of watchmen. In the instance of failure to forward a request for security plan changes to NRC HQ within 2 months, the licensee wrote a procedure to guide his managers on how to make authorized changes to the plan. The revalidation of unescorted access to vital areas was included in a security procedure to insure the procedure would be accomplished every 31 days on all vital areas.

4/10/80 Licensee Ltr.

To resolve the item of noncompliance relative to obstructions in the isolation zone, a memorandum was sent to all division heads to re-emphaszie the requirement to maintain isolation zones free of obstructions.

9/15/80 Licensee Ltr.

Contention E

"The Salem facility displayed evidence of weakness in the area of management controls."

1. Basis

References

The licensee has displayed difficulty in effectively implementing an adequate system of

LERs 80-19, 80-21 80-27, 80-28,

management controls. Examples are: missed surveillance testing; degradation of physical security (see Contention D); failure to properly apply station tagging rules; and, failure of operators to comply with station procedures (see Contention "A").	80-42 IE Reports 50-272/79-26, 80-17, 80-13, 79-32, 80-20, 79-28, 80-05, 80-06, 80-12, 80-20

2. NRC Actions

	References
The NRC issued Notices of Violation addressing each specific finding discussed above. Particular emphasis was placed on management control weaknesses by the NRC during the management meeting in which the SALP results were discussed with the licensee. The NRC continues to closely monitor the licensee's performance in this area.	IE Reports 50-272/80-26 50-311/80-19

3. Licensee Corrective Actions

	References
The licensee has committed to take actions to correct the specific items identified above. In addition, the licensee has taken steps to improve management involvement with plant activities. Responsibility for the licensee's nuclear facilities now resides under the General Manager-Nuclear Protection. Responsibility for the fossil fuel facilities now resides under a separate General Manager. Further, the licensee reorganized the Quality Assurance organization enhancing the independence between QA activities and plant operations. At the licensee's request a management meeting was held on December 10, 1980 at NRC Region I to discuss the proposed reorganization.	Licensee letters of: 9/15/80 10/6/80 8/15/80 7/2/80 4/10/80 1/6/81 NRC Letter (TS Amendment #31) 12/23/80 NRC Letter

Contention F

"Although the station staff demonstrated an ability to identify problems and propose solutions, there were instances where corporate management did not provide a timely response."

1. Basis	References
Routine NRC inspections during the assessment period identified items of noncompliance indicative of the problem discussed above, particularly involving design changes and modifications. Examples include: failure to develop master equipment lists and a method to provide to the plant, timely "as built" information; failure to provide the required information in a design change/modification package; failure to protect and maintain design records; and, failure to review Engineering Department procedures.	IE Reports 50-272/79-28, 79-33, 80-04, 80-19 and 50-311/ 80-01, and 80-14
An additional item of noncompliance related to the failure of the Training Department to train licensed operators in facility design changes in a timely fashion. This failure resulted from the inability of the Training Department to obtain design change information from the corporate office.	IE Reports 50-272/80-15 and 50-311/80-10

2. NRC Action

Enforcement action was taken for each specific item of noncompliance identified. The NRC continues to monitor licensee performance.	NRC letters of: 1/2/80 3/7/80 5/6/80 7/29/80 9/29/80

3. Licensee Corrective Actions

Corrective action was implemented by the licensee to address each item of noncompliance identified. Additionally, the licensee took steps to improve corporate and site management involvement in and responsiveness to plant activities by implementing a reorganization of corporate and site management. This reorganization is further discussed in Contention E.	Licensee letters of: 1/22/80 4/7/80 6/3/80 8/19/80 10/17/80 12/23/80 NRC letter; 1/6/81 NRC letter (TS Amendment #31)